A Dance/Movement Therapy Clinical Model for the Treatment of School Aged Children Who are Victims of Sexual Abuse: A Literature Based Study

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Dedications

I dedicate this thesis to the four most important people in my life.

To my parents; you have always loved me unconditionally and always pushed me to reach my full potential.

To my sister; you have taught me how to laugh, how to be patient, and how when you have to struggle for something you want, it makes it that much sweeter when you get it.

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Abstract
A Dance/Movement Therapy Model for the Treatment of School Aged Children who are Victims of Sexual Abuse: A Literature Based Study
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This literature based study was a review of theoretical, practice, and research literature regarding the effects of sexual abuse on children and their subsequent treatment. The review was focused on psychotherapy literature that addressed the trauma of sexual abuse specifically and other forms of childhood trauma. Foundational models for using dance/movement therapy (DMT) to treat abuse in children were developed in the 1980’s during an increased societal awareness of this problem. An explosion of research and literature in many fields since the 1980’s, was directed toward understanding and treating this population. In addition to the work done in DMT, much of the literature by other professionals recommended using body-based treatment approaches. However, there were updated DMT models for treating sexually abused children that incorporated recent literature and research in other psychotherapy fields. The objective of this research study was to create a comprehensive DMT clinical model for therapy with children who were victims of sexual abuse. Based on preliminary literature review, the model was directed toward a long term, group therapy format for school aged children, approximately 6-12 years of age. The literature review was focused on the past ten years however foundational sources were reviewed to provide a context for recent developments in the field. Relevant information from all sources was abstracted and organized into four review matrices (Matrix 1-3 non-DMT, Matrix 4 DMT): 1) Effects in sexually abused or otherwise traumatized children, 2) Treatment
concerns and overall guidelines for therapy, 3) Specific treatment models and methods, and 4) DMT methods for treatment of sexually abused or otherwise traumatized children and adult survivors of trauma including childhood sexual abuse. An analysis of matrices 1-3 identified the central effects observed in therapy with this population and the key treatment techniques used. The selected effects and treatment techniques were synthesized into eight essential treatment categories. An analysis of Matrix 4 was completed to summarize supporting DMT techniques for use with abused children. These DMT treatment concepts and other DMT theory and practice information were used to create a clinical DMT model to address the eight treatment categories within a three phase format; beginning, middle and ending treatment phases. The model was presented as full text and in a summarized table format. The model can be adapted for short term therapy and specific categories can be selected based on the needs and progress of children in therapy. This model can be effectively used by dance/movement therapists and other psychotherapists. This literature review and completed model provides strong support for DMT as a primary tool to help sexually abused children regain their sense of self and progress toward becoming healthy adults.
CHAPTER 1: INTRODUCTION

Current dance/movement therapy (DMT) with children who were victims of different types of trauma was based on clinical models written in the 1980’s during an increased professional and societal awareness of child sexual abuse that required an expansion of understanding and treatment. Models such as those of Goodill (1987) and Weltman (1986) continued to be foundational references for research in DMT and guidance for dance/movement therapists who worked with this population (Brenner, 1995; Mills & Daniluk, 2002; Truppi, 2001). After the 1980’s, there was an explosion of research and literature directed toward understanding trauma and the treatment of trauma victims. There were research studies in dance/movement therapy, at the Master’s level, that addressed the use of DMT with sexually abused, school aged, children (Biggins 1989; Brenner 1989; Holecek 2000; LeMessurier, 1990; Pupello, 1996; Wegrzyn, 1993). Primarily, these studies were either individual or group case studies or efforts to assess and understand non-verbal characteristics in children that might indicate a history of sexual abuse. Often information in these studies was generalized to all ages of children and did not specifically address school aged children. This generalization to all ages of sexually abused or otherwise traumatized children was also present in more recent DMT literature on this topic (Ben-Asher & Koren, 2002; Kornblum & Halsten, 2006; LeMessurier & Loman, 2008).

An integral finding in literature and research by researchers and therapists since the 1980’s was that trauma had a strong effect on the body. Interestingly, researchers not involved in DMT suggested that a body based therapy approach could address the resulting issues from trauma: dissociation, multiple personality disorder, eating
disorders, somatization disorder, self-mutilation, and suicide attempts (Herman, 1992; Ogden, Minton & Pain, 2006; Rothschild, 2000; van der Kolk, 2003; Young, 1992). Research to study the possible neurological effects of trauma on children and adults revealed that traumatic experiences affected children on a developmental level by interfering with their assimilation of sensory, emotional, and cognitive information into an integrated whole. This disruption of integration caused unfocused and irrelevant responses to future stress (Streeck-Fischer & van der Kolk, 2000). Other neurological effects of trauma included: hyper-arousal (Kendall-Tackett, 2000), abnormalities in the neurotransmitters that regulated arousal and attention (van der Kolk, 2002), and physical, conditioned responses such as flight/fight/freeze that were triggered during non-threatening situations (van der Kolk, 1999).

Researchers and therapists that specifically studied sexual abuse in children, reported very diverse effects of sexual abuse but did not observe or identify a specific syndrome in these children (Putnam, 2003; Saywitz, Mannarino, Berliner & Cohen, 2000). Putnam (2003) described childhood sexual abuse as a complex life experience rather than a set diagnosis or disorder. Since sexual activities that occurred during sexual abuse were very diverse, their effects were also varied. Other factors that complicated the outcomes of sexual abuse included the age and gender of both the child and the perpetrator(s); the type of relationship between the child and perpetrator; and the number, frequency, and duration of the abusive experiences. Gordon and Schroeder (1995) observed that the effects of sexual abuse often depended on the developmental level of the child. Sexually abused children were a very heterogeneous group. Therefore, any treatment structures had to be adjusted for the developmental level of the child.
Additional research supported providing treatment for sexually abused children in a long term format due to their complex and diverse issues and painful experiences that had to be addressed at the child’s own pace (Dripchak, 2007; Jones, 2002; LeMessurier & Loman, 2008; Ryan & Needham, 2001).

Dance/movement therapy provides unique skills for working with children of all ages with a variety of issues. Infants and children have rapidly changing bodies and they experience the world through their bodies; therefore, DMT provides a specific way to use their method of experiencing (American Dance Therapy Association, ADTA, 1999). Children’s bodily experiences also help establish their emotional, social, physical, communicative, and cognitive development. Dance/movement therapy methods allow children to participate in meaningful explorations of the self, the environment, and others (Erfer & Ziv, 2006). Children use movement as a way to communicate and the natural enjoyment of movement helps motivate children to learn and remember the skills taught in DMT (ADTA, 1999). Dance/movement therapy is action-based and it can also incorporate verbalization and vocal exchanges. However, since DMT doesn’t rely on verbal language for communication, clients do not need a high level of language skills to participate. Dance/movement therapy is a particularly effective tool when working with children who haven’t developed many language skills or lack these skills due to language, learning, or communication difficulties (Payne, 1992). The DMT emphasis on non-verbal communication makes it an ideal treatment method for a wide range of populations from normally developing infants and children to children who struggle with various conditions (ADTA, 1999).
There are various characteristics that enhanced receptivity of school aged children (6-12 years old) to therapy and treatment for sexual abuse. School aged children were described as having a behavioral pattern of “calm, pliability, and educability” (Sarnoff, 1987, p.5). At these ages children began to combine skills learned in earlier developmental stages to carry out new tasks. Lack of certain skills, an effect of sexual abuse, became more noticeable and easier to target in therapy during this stage of development (Brenner, 1995). Also during this stage of development, advances in reasoning ability about the physical world helped school aged children deal with complex situations such as trauma related experiences. The increase in flexibility allowed children to have a broader perspective on their problems; an essential factor in the therapy process where these abilities were often required (Newman & Newman, 2006). School aged children were at a stage of development where they could both comprehend a significant amount of material addressed in therapy and also developed new skills. At this age children were still young enough that, in addition to treating the symptoms already present, some interventions could be preventative.

This literature based study reviewed and compared foundational and recent trauma literature within and outside the field of DMT. The purpose was to integrate the current understanding and treatment of trauma into a DMT clinical model for early intervention therapy with school aged children who were sexually abused. The limited quantity of literature available on DMT treatment methods with school aged children presented a challenge when creating the DMT clinical model in this study. This updated DMT clinical model helps dance/movement therapists provide quality therapy for these children. Secondly, this study supports delineation of the body based approaches that are
unique to DMT that can enhance the discussion of trauma and its treatment in the wider professional community.

1.1 Historical Background

In the early to middle 1980’s, the awareness and concern about sexual abuse trauma grew and triggered an increase of information and discussion of sexual abuse in both public and professional arenas: the media, schools, and conferences (Sgroi, 1982, 1988). By the end of the 1980’s there was an increased number of sexual abuse victims and their families seeking treatment. In addition sexual abusers began seeking treatment (Sgroi, 1988). The increased awareness and requests for treatment, stimulated both research and clinical efforts to understand the effects of sexual abuse trauma and improve treatment for clients involved in traumatic experiences (Sgroi, 1988). Sgroi’s (1982) foundational work focused on the symptoms and treatment of sexually abused children and adult survivors. She organized the effects and treatment issues for sexually abused children into ten main issues: 1) ‘damaged goods’ syndrome, 2) guilt, 3) fear, 4) depression, 5) low self-esteem and poor social skills, 6) repressed anger and hostility, 7) impaired ability to trust, 8) blurred role boundaries and role confusion, 9) pseudo-maturity with failure to accomplish developmental tasks, and 10) self-mastery and control issues. van der Kolk (1988) discussed four research approaches: 1) biological changes that underlie the psychological responses humans make to trauma, 2) how these changes affect the nervous system and brain development, 3) how biological changes can influence psychopathological and interpersonal processes, and 4) how they can be addressed in treatment.
In the 1980’s Goodill (1987) and Weltman (1986) provided foundational theoretical frameworks and clinical examples of DMT with children victims of sexual abuse. Goodill (1987) explained that DMT helps these children to: 1) regain a sense of control and ownership over their bodies and personal space, 2) more easily tell about their experiences through non-verbal expression and the use of symbolism, and 3) be more assertive by using certain movements and movement qualities. Weltman (1986) discussed how movement amplifies affect through the sense of touch during DMT for sexually abused children. She recommended ways to use touch therapeutically to facilitate the child’s awareness and integration of the abusive experiences. Weltman also proposed that DMT can be effective with sexually abused children because movement helped restore body integrity and control and allowed them to regulate their responses, a skill that was lost due to the abuse.

Over the past ten years, literature and research on trauma continued to expand. Cook et al. (2005) and Hetzel-Riggin, Brausch, and Montgomery (2007) reviewed the recent span of literature that addressed childhood sexual abuse. Cook et al. (2005) reviewed literature on trauma and organized the impairment seen in child trauma victims into seven main areas: 1) attachment, 2) biology, 3) affect regulation, 4) dissociation, 5) behavioral control, 6) cognition, and 7) self-concept. This increase in understanding about the impact of trauma, particularly sexual abuse, has helped therapists and others create more effective therapy models. Hetzel-Riggin et al. (2007) conducted a meta-analysis research study on the outcomes of several current therapy models including: 1) play therapy, 2) group or individual cognitive-behavioral therapy, 3) abuse specific therapy, 4) supportive therapy, 5) group therapy, and 6) family therapy in the treatment of
sexually abused children and adolescents. They reported that psychological treatment after sexual abuse produced better outcomes than no treatment at all, and depending on the symptoms being targeted in therapy, different therapy methods may be more effective than others (Hetzel-Riggin et al., 2007).

Some researchers and therapists, despite their support and use of therapy methods for treating sexually abused children, advised caution when working with this population because of the possibility of re-traumatization or other negative effects during early intervention treatment (Gordon & Schroeder, 1995; van der Kolk, 2002). Gordon and Schroeder (1995) discussed two factors: 1) how interventions can exacerbate issues resulting from abuse, and 2) that disclosure of abuse causes severe disruptions to family systems at a time when the child needs their support the most. They stated it is important for therapists to be aware of family and environmental factors of the child before starting treatment. Cohen (2003) stressed that little research has been conducted to examine the positive or negative impact of providing early interventions to traumatized children.

Dance/movement therapists have continued to treat children who have been sexually abused using the body based therapy model of DMT that was initiated by Goodill (1987) and Weltman (1986). Ben-Asher and Koren (2002) described how transference and countertransference can be used uniquely in DMT, particularly with abused individuals, based on a case study with a five year-old girl. Dance/movement therapists used their ‘inner sonar’ to receive somatic information by observing how their client reacted physically to therapeutic interactions. The client’s physical body movement helped the therapists discover underlying sources of distress resulting from her traumatic experiences that were physiological in nature, even before the client had
verbalized her experiences (Ben-Asher & Koren, 2002). In her doctoral research, Truppi (2001) compared the effectiveness of two forms of therapy, a multi-model form of verbal therapy and DMT, on the self-concept, shame, and trauma symptoms of sexually abused adolescent girls. There were no significant results from either form of therapy on these symptoms; however, this research provided an in-depth evaluation of using body-based therapy methods of DMT in the treatment of sexually abused children. Truppi presented literature that supported DMT therapy in contrast to the verbal therapy methods more commonly used with this population.

The available literature on DMT treatment of both trauma and treatment of adult survivors of sexual abuse is more extensive and has relevance to DMT work with sexually abused children. Meekums (1999) used research with adult survivors of childhood sexual abuse to create a model for the recovery process and suggested that creative arts therapies can provide helpful interventions for these individuals. Other research by Ambra (1995), Mills and Daniluk (2002), and MacDonald (2004) clarified the techniques of DMT that were successful when treating women survivors of childhood sexual abuse. Valentine (2007) concluded, through her DMT work with women survivors of sexual abuse, that these women tend to separate from their inner sensations as well as from their connections with other people. Valentine (2007) stated that “dance/movement therapy, a psychotherapy that focuses on the body, is uniquely qualified to address these consequences because it supports the creativity of clients, empowering them to find a more compassionate, integrated relationship with their bodies” (Valentine, 2007, p. 181).
Recent DMT literature described the use of DMT to treat the effects of other forms of trauma, besides sexual abuse, on children and adults. Harris (2002, 2007) studied children affected by war and organized violence and created a community-based, preventative, intervention program that incorporated DMT. He proposed that to reach these children, DMT can be converted to a community-based practice with dance/movement therapists acting as community organizers. Harris (2007) also conducted time-limited DMT groups, facilitated by adult males, for adolescents who were involved in wartime atrocities. Harris combined western trauma treatment methods with rituals for success in helping these adolescents overcome their violent impulses and rediscover the joy of working together with others. Another study on the treatment of trauma is Holloway’s (2006) literature based Master’s research to identify effective techniques in DMT and other fields of therapy that support safety and containment during therapy with trauma survivors. Holloway suggested that the field of DMT has numerous skills to provide safety and containment but the field of would benefit from developing and researching additional safety and containment skills. She suggests for example, that the Kestenberg Movement Profile (KMP) could be used to translate skills from Dialectic Behavior therapy (DBT), to improve the effectiveness of DMT with trauma populations (Kestenberg, 1975 as cited in Holloway, 2006). Gray (2001) used DMT to successfully treat a woman who survived torture and concluded that DMT can help torture victims rebuild their sense of wholeness and self, improve their interactions skills, and increase their ability to form relationships.
1.2 Summary of the Research Study

In this literature based study theory, practice, and research literature was reviewed from the past ten years pertinent to the effects of sexual abuse on children, and the treatment of school aged children, ages approximately 6-11, who were victims of sexual abuse. In addition to this recent literature, foundational sources were included to provide a context that informed recent developments in the field. This review focused on psychotherapy literature that addressed sexual abuse trauma and trauma in general as it encompasses child sexual abuse. The scope of the DMT literature that was included was more broadly defined as foundational and recent literature on DMT with children in general, and DMT with adult and children victims of trauma and sexual abuse specifically. The literature reviewed in this study was primarily within the scope of western literature. Therefore the results, outcome, and conclusions of this study can not be generalized to non-western cultures. Therapists who use information from this study must be aware of the cultural background of their clients and make adjustments to ensure treatments are culturally appropriate.

Overall, the literature appeared to provide a rationale for the inclusion of body based methods in the treatment of trauma. The need to create a body based therapy model that incorporates the recent relevant literature on trauma treatment, particularly the treatment of sexually abused children was identified. The research question for this study was: how can DMT address the needs of school aged children, who were victims of sexual abuse, by integrating DMT approaches with recent literature and research that supports a body based therapy method for treating child victims of sexual abuse? The objective of this study was to create a DMT clinical model for therapy with school aged
children who were victims of sexual abuse. The literature review was conducted using Garrard’s matrix method. Relevant information from areas of recent literature, outside the field of DMT, was abstracted into three review matrices based on the main themes and objectives of the study: 1) effects of trauma and sexual abuse in children, 2) guidelines and concerns in treatment of trauma and sexual abuse in children, and 3) treatment methods and guidelines for working with traumatized and sexually abused children. The data from the three review matrices were analyzed and eight treatment categories were created for treating this population. Literature on: 1) DMT methods for treatment of sexually abused or otherwise traumatized children, and 2) treatment of adult survivors of trauma including childhood sexual abuse, was abstracted separately into a fourth review matrix. Analysis of this fourth matrix identified DMT methods and theories available to address the eight overall treatment categories. Additionally, foundational literature, general information on DMT, and information gained from personal experiences in dance movement therapy with children, informed this treatment model. The DMT clinical model created in this study is in a group therapy, long-term, child only therapeutic format and is divided into beginning, middle, and end phases.

The stated objectives of this study were met however, there were limitations in the literature review. Although the scope of literature was limited to the last ten years, there was more information than could realistically be covered in this study. In most areas it was possible to reach the point of saturation with regards to for the information provided, however, in a few literature areas, I made informed literature selection decisions. This clinical model provides support for the use of DMT to address the needs of sexually abused children as determined by both dance/movement therapists and non-
dance/movement therapists. It is the hope that this DMT clinical model will help
dance/movement therapists in their continued work with sexually abused children. In
addition in would be encouraging if the synthesis of literature and DMT clinical model
presented in this study would motivate future research, and support the increased
inclusion of DMT in the discussion of assessment and treatment of these children.
CHAPTER 2: LITERATURE REVIEW

2.1 Childhood Sexual Abuse as a Form of Trauma

2.1.1 Definition and Prevalence

Trauma is defined by the DSM-IV-TR as the “direct personal experience of an event that involves actual or threatened death or serious injury” or witnessing or hearing about an event that involved death or serious harm of another person (American Psychiatric Association, APA, DSM-IV-TR, 2000, p.463). The concept of trauma encompasses a wide range of experiences that shared fundamental similarities. A particular type of trauma might also have unique aspects. The effects of different types of trauma on individual victims can have similarities or vary according to the nature of the trauma. Therefore, treatment options for traumatized people include both an overarching approach and unique techniques specific to the type of trauma. Trauma is often discussed as a general topic with recognition that there are similar effects on all trauma victims. Conversely, in most other literature the effects of a specific form of trauma are differentiated and authors propose that this differentiation is important. This research study includes a review of both general literature on childhood trauma and literature with a specific focus on childhood sexual abuse. For this literature review, sexual abuse is considered a form of trauma with unique aspects that differentiate it from other forms of trauma.

It is generally accepted that victims of sexual abuse have experienced trauma. Sexual abuse is linked to childhood post traumatic stress disorder (PTSD) symptoms and internalized symptoms (Whiffen & MacIntosh, as cited in Briscoe-Smith & Hinshaw, 2006). Dubner and Motta (1999) investigated this potential relationship between child...
sexual abuse and PTSD. They compared test scores of physically and sexually abused children with non-abused children using the Child Post Traumatic Stress Reaction Index (CPTSD-RI), the Childhood PTSD Interview (CPI), and the Modified Stroop Procedure (MSP) that used sexual abuse and nonsexual abuse stimuli. The results of the combined CPTSD-RI and the CPI scores revealed that 64% of the sexually abused group, 42% of the physically abused group, and 18% of the non-abused group were diagnosed with PTSD according to the DSM-III-R diagnostic criteria. The differences between each group were significant. Research by Kendall-Tackett (2000) on how trauma could affect brain function revealed that one of the three common and often present symptoms of childhood abuse was PTSD. Symptoms seen in people with PTSD and sexual abuse included “persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and increased arousal” (APA, DSM-IV, 1994, p.424).

Victims of childhood sexual abuse have experiences that meet the DSM-IV definition of trauma. A sexually abused child is physically and emotionally violated in numerous ways. Physical violence might be used to force a child to perform sexual acts and face threats of death or injury if he or she is not compliant. Violations such as fondling and being forced to give fellatio might cause mainly emotional trauma, while violations such as penile or object penetration can cause serious physical injury, especially if the abuse is chronic (Young, 1992). Bannister (2003) explains that sexually abused children are usually threatened by the perpetrator to keep quiet to avoid death or injury to themselves or to the other people they care about.

Surveys conducted on the prevalence of sexual abuse, indicate that child sexual abuse is a significant concern. According to Child Maltreatment 2005, a report of data
from the National Child Abuse and Neglect Data System (NCANDS), approximately 899,000 children were victims of child abuse or neglect in 2005. Of this number, 9.3% were sexually abused (National Child Abuse and Neglect Data System, nd).

2.1.2 Unique Aspects of Sexual Abuse Trauma

The trauma of sexual abuse has unique aspects that distinguish it from other forms of trauma. The main differentiating aspect is that sexual abuse is emotionally confusing for a child. A child might have positive associations with the abuse such as the pleasurable physical feelings of sexual arousal or the special attention and treatment from a caregiver. A very young child might not understand that the abuse is pathological. Sexual abuse can seem to be “loving”, “gentle” and “subtle” (Myers, 2007, p. 121). This can cause children to not recognize that the sexual activity is abusive (Donovan & McIntyre, as cited in Myers, 2007). These experiences could perhaps be even more confusing for a child who understands that the abuse isn’t good or natural but involves positive experiences just the same. Sexual abuse is almost always handled as a secret between the abused and the abuser. In cases where other members of a family are aware of the sexual abuse and do nothing the abuse becomes a family secret. Other forms of physical abuse can be kept secret but the physical marks and injuries are often more obvious, the abusive acts are harder to conceal, and the abusers can often use the excuse that they are “disciplining” the child rather than abusing them (Young, 1992). In a book chapter concerning the development of latency aged children, Cincotta (2002) explains that physical injuries from sexual abuse are more easily hidden such as vaginal discharge, injuries to or inflammation of the genitalia, and signs of other physical abuse. Hutchison (2005) describes in her book on the effects and interventions for childhood trauma, how
the injuries of sexual abuse are exhibited indirectly through somatic symptoms such as headaches, dizziness, stomach pains, and difficulty breathing.

The definitions of child sexual abuse varied slightly depending on the source and the breadth of the definition presented. Child sexual abuse was defined by McGee, Garavan, de Barra, Byrne, & Conroy (as cited in Edwards & McFerran, 2004) as any unwanted or inappropriate sexual behaviors with a child that included: 1) verbal contact, 2) genital contact, or 3) penetration with the fingers (digital penetration), the genitals or another object. Putnam (2003) provided a definition of child sexual abuse activities that included: 1) intercourse, 2) attempted intercourse, 3) oral-genital contact, 4) fondling of genitals directly or through clothing, 5) exhibitionism or exposing children to adult sexual activity or pornography, and 6) use of the child for prostitution or pornography.

2.2 Normal Development in School Aged Children

This study focused on the incidence and treatment of sexual abuse in school aged children, and required inclusion of a brief review of normal development during this developmental stage. It was beyond the scope of this study to include a survey of all literature related to school aged children. Therefore, two main sources were summarized: Newman and Newman’s (2006) authoritative text that synthesized current understandings of development, and Cincotta’s (2002) discussion on latency age child development.

The developmental stage of age 6-12 is sometimes also referred to as middle childhood or latency age. It is defined by the skills that children are learning; the changes that are occurring physically, emotionally, and cognitively; and by the nature of the child’s relationships. School aged children begin to acquire many new abilities, and become skilled learners by contributing what they already know to the performance of
new tasks (Newman & Newman, 2006) and developing concrete operational cognitive skills (Piaget & Inhelder, as cited in Newman & Newman, 2006). Concrete operational thinking begins to develop when a child is 7 or 8 years old and is characterized by correct reasoning about situations and objects despite changes in appearances. School aged children begin to focus more on self-evaluation and try to match their achievements with internal goals and external standards. Self-evaluation for these children becomes more complicated as peer groups are added as a source of comparison, criticism, and approval. During this stage of development, children become focused on making friendships and begin to extend their significant relationships beyond the family to include classmates, team mates, and close friends (Newman & Newman, 2006). These relationships beyond the family circle begin to influence the child’s thinking and behavior. Children begin to participate in team sports and therefore begin to gain a sense of team success in addition to individual success. Membership in a team teaches these children interdependence, cooperation, and competition (Newman & Newman, 2006). Children at this stage usually prefer to play with same sex peers (Hartup, as cited in Cincotta, 2002) and their advances in the ability to reason about their physical world help them deal with complex situations, particularly social ones. In turn, experience dealing with these situations might help children develop flexibility and a broader perspective on problems.

Cincotta (2002) states that school aged children start to think more autonomously, assert their independence, and establish themselves as unique individuals. They are inquisitive and always want to know more about everything. They experience changes such as starting school and changing schools from elementary to middle school. Rituals and routines help provide structure for school aged children as a way to cope with the
many changes, new issues, and experiences that occur. Physical development occurs more gradually during this period than in either earlier childhood or later adolescence, but children do grow 2-2.5 inches per year and double their weight from approximately 40 lbs to about 80 lbs. These physical changes cause school aged children to feel stronger and more capable in various tasks. The ability of children in this stage of development to differentiate between themselves and their parents and understand that they have a separate reality supports many emotional developments. School aged children have an understanding of gender constancy, and begin to develop a sexual identity and an understanding of their role in the family. The ability to use language as a cognitive skill causes changes in memory functioning and they begin to realize that they can both remember and forget their experiences. These children have the ability to keep secrets because they can hide their intentions. They are often joyful and happy since they are not yet concerned by adult worries and can enjoy each moment to the fullest. They are usually more resilient when faced with a crisis than older children. However, they still can experience psychological difficulties as a response to crisis (Cincotta, 2002).

Sexual development in school aged children is marked by sexual experiences that are “attempts on the part of the organism to express drives in the absence of a mature physiological organization for discharge, namely an exclusive effecter organ and an object” (Sarnoff, 1987, p.12). Sarnoff (1987) explains that school aged children show sexual urges through genital stimulation that causes some degree of erotic sensory response, and by playing out fantasies with whole body movement. Between the ages of 9-12, sexual sensations from the genitals increase to the point that ejaculation and orgasm are possible, and masturbation also increases. Sarnoff describes how children at this stage
of development are often discouraged from masturbating by adults. As children age out of this stage of development, sexual fantasies become more realistic and involve real people in their lives (Sarnoff, 1987).

2.3 Foundational Literature on Trauma Therapy and Research

A review of the history of trauma therapy and research provided a context to understand how treatment for sexually abused children was related to other trauma therapy. There were two important historical landmarks that affected the study of trauma: 1) the addition of Post Traumatic Stress Disorder (PTSD) to the Diagnostic Statistical Manual (DSM) in 1980 and 2) the 1987 acknowledgment that PTSD could be diagnosed in children (Feather & Ronan, 2006).

2.3.1 Foundational Research on Effects of Trauma

Some of the earliest research on the effects of trauma was summarized by van der Kolk (1988) as: 1) biological alterations in response to trauma, 2) dependence of biological alterations on the maturity level of the central nervous system and cognitive processes, and 3) effect of alterations on psychopathological and interpersonal processes. The psychological responses of humans to trauma were linked to underlying biological changes that affected nervous system and brain development. Patterns of hyper-arousal, alternated with numbing, as reactions to traumatic experiences that indicated an underlying biological effect (van der Kolk, as cited in van der Kolk, 1988). Hyper-arousal could cause avoidant and escape behavior as a psychological defense and also as a physiological response to reduce regulation of receptors in response to over stimulation. A comparison of how immature humans and other animals that experienced prolonged and extreme stress responded to shock revealed that humans might react similarly to
animals. Exposure to stressful environments in childhood caused increases in autonomic
and endogenous opioid response to stressors that could continue into adulthood.

Traumatic experiences were overwhelming and did not fit into an individual’s conceptual
schemata; therefore, traumatic experiences were often not assimilated by the individual
on a cognitive level. Instead, experiences were stored on a sensorimotor or iconic level
as images, sensations, or fight/flight/freeze reactions (Eich, as cited in van der Kolk,
psychopathological and interpersonal processes. Since increased levels of arousal in
traumatized people decreased their ability to assess challenges and stressful situations, it
was difficult for them to resolve and integrate trauma. They moved quickly from
stimulus to response without thinking and made it difficult for people to relate to them.

Herman (1992) conducted foundational research and clinical work with various
populations of traumatized individuals. Her two decades of work on the effects and
treatment of trauma for adults and children was synthesized in *Trauma and Recovery*.

Herman placed the effects of trauma in three main categories: 1) terror, 2) disconnection,
and 3) captivity. The category of terror included effects such as hyper-arousal, traumatic
memory intrusion, and constriction of experience, numbing, and dissociation.

Disconnection effects included: 1) damage to the sense of self through losses of both the
sense of safety and the secure connection with caring people, 2) damage to relationships,
3) positive or negative responses by others that could support recovery or damage and
aggravate symptoms, and 4) response of the community to a traumatized individual.

Herman discussed how all prolonged trauma essentially occurs in captivity. If an
individual was free to escape the trauma it would not continue. When someone was held
captive they might have experienced psychological domination by being forced to surrender. They might have developed the syndrome of chronic trauma and have long lasting, deeply damaging effects on the personality.

2.3.2 Foundational Treatment Methods

In addition to conducting research on effects of trauma, van der Kolk (1988) addressed treatment implications for this population. He discussed successful treatment of acute post-traumatic anxiety in adults using verbal therapies and medication. Hypnosis was an effective treatment to retrieve traumatic memories (Spiegel, as cited in van der Kolk, 1988). Once traumatic memories were retrieved within a context of time and place, clients could distinguish between past trauma and current stressors to decrease the impact of past trauma on their present life. van der Kolk (1988) explained that traumatized clients often resisted psychotherapy and especially resisted remembering traumatic experiences that they worked hard to repress and forget. It was important to create a secure bond and attachment with the client before trauma was addressed. Gradually addressing trauma related material reduced the potential for intensification of affect and physiological states that could cause traumatic re-experiencing.

Herman (1992), similar to van der Kolk, provided foundational information and guidelines for treatment of trauma that therapists have continued to use. Herman (1992) concluded the two key experiences of psychological trauma were disempowerment and disconnection. Therefore, treatment goals involved empowering the client and helping them make new connections with others to regain relationship skills and the supportive benefits of relationships that were lost during the trauma. Examples of these relationship benefits were: 1) the capacity to trust, 2) a sense of autonomy, 3) taking initiative, 4)
gaining a sense of competence, 5) creating self identity, and 6) gaining intimacy. In achieving this empowerment, the therapeutic relationship allowed the client to have control over treatment while providing support and the techniques to heal. Herman (1992) stated that recovery occurred in three stages: 1) the establishment of safety, 2) remembrance and mourning, and 3) reconnection with ordinary life. These three stages occurred in order and were an attempt to help the client make sense of the confusing process of recovering from trauma. Safety was established through the creation of a safe place to conduct therapy and development of a safe and trusting relationship between the therapist and client. Safety was recreated by returning power and control to the survivor.

In the second stage of recovery, the survivor was given a chance to tell the story of his or her traumatic experiences completely and in detail. This retelling supported integration of the traumatic experience into their life story. The client continued to exercise control by having the right to decide how quickly to remember the trauma. Although this difficult process was often resisted by the client, it was considered important that he or she fully mourned the losses from the trauma. To heal, the client had to reclaim all emotions, including loss, to reintegrate his or her sense of self. Following completion of the first two steps, trauma survivors needed to find a way to move forward, learn to create new relationships and integrate new beliefs about themselves and the world around them.

Foundational literature that focused on specific treatment methods included the research of De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy (1992) on group therapy for abused children. Their theories and methods have continued to be used in group therapy with this population. De Luca et al. (1992) described a group therapy program for pre-adolescent boys and girls who were victims of intra-familial sexual abuse. Their
rationale for using group therapy with victimized children was it provided: 1) a chance to socialize, interact, and reconnect with peers, 2) interactions with peers to help establish a support network outside of the family, 3) a range of educational opportunities, 4) a more cost effective treatment method, 5) therapy without active involvement of families of victims, and 6) a strong possibility of reducing the negative symptoms that result from sexual abuse. Group therapy provided a setting where abused children healed by learning to: 1) develop and enhance social skills, 2) use effective and healthy ways to interact with others, 3) discover how other children cope with their abusive experiences, 4) identify alternative ways to deal the problems that they face, 5) practice new behaviors with feedback from others, and 6) engage in role-playing to prepare for events, such as testifying in court, or to feel mastery over previous experiences. All group therapy for children with sexual abuse had similar goals: 1) help children to identify, accept, and express feelings, 2) reduce the level of negative affect, 3) help children put the blame on the abuser, 4) give sex education, 5) reduce vulnerability to re-victimization, 6) give children a chance to develop healthy relationships with peers and adults, and 7) help children develop self-confidence and personal identity.

2.4 Foundational Literature on Sexual Abuse Therapy and Research

Before the 1980’s, sexual abuse of children was not openly discussed in most environments and people rarely sought treatment for sexual abuse (Sgroi, 1988). In the early to mid 1980’s, there were increases in awareness and concern about sexual abuse trauma, both in children and in adult survivors of childhood sexual abuse. This concern grew in conjunction with increases in information and discussion of sexual abuse in public and professional arenas: the media, schools, and professional conferences. This
heightened awareness stimulated research and clinical work to understand effects of sexual abuse trauma and improve treatment for clients with these experiences (Sgroi, 1988). Augoustinos (as cited in Brenner, 1995) stated that there was sufficient evidence that childhood sexual abuse caused a complex of negative influences on the child’s physical, neurological, intellectual, psychological and emotional development.

2.4.1 Foundational Research on Effects of Sexual Abuse

Foundational research by Porter, Blick, & Sgroi (1982) on the effects of sexual abuse on children was presented in *Handbook of clinical intervention in child sexual abuse*. The ten main issues they highlighted to address during therapy with sexually abused children were: 1) ‘damaged goods’ syndrome, 2) guilt, 3) fear, 4) depression, 5) low self-esteem and poor social skills, 6) repressed anger and hostility, 7) impaired ability to trust, 8) blurred role boundaries and role confusion, 9) pseudo maturity with failure to accomplish developmental tasks, and 10) self-mastery and control issues. Early work by Suffridge (1991) introduced the control-mastery theory to formulate psychological effects of child-maltreatment and identified implications for treatment. Suffridge described observable effects of child-maltreatment as: 1) delayed or impaired cognitive development, 2) negative self-perceptions and low self-esteem, 3) negative affect, 4) constricted emotional expressiveness, 5) difficulty identifying emotions in self and others, 6) problems in interpersonal relationships, 7) inappropriate sexual or aggressive behavior, 8) increased risk of developing depression or anxiety disorders, 9) psychosomatic symptoms and disassociative symptoms, and 10) development of multiple or borderline personality disorders.
Another important study by Deblinger, McLeer, Atkins, Ralphe & Foa (1989) compared levels of posttraumatic stress in sexually abused, physically abused, and non-abused children. The results showed that 20.7% of sexually abused children, 6.9% of physically abused children, and 10.3% of non-abused children in the study met the criteria for posttraumatic stress. Although differences between the three groups were not significant for posttraumatic stress in general, sexually abused children did show significantly higher levels of certain behaviors, for example, inappropriate sexual behavior. Both sexually and physically abused children showed higher rates of avoidant/disassociative symptoms when compared to non-abused children.

Bauman (1988) conducted research on the impact of sexual abuse on latency-age girls. In this study, Bauman created a foundation and rationale for her research based on the reported impacts of sexual abuse on children from established researchers. Bauman evaluated 30 sexually abused girls, age 6 1/2-13, relative to their level of depression, anxiety, self-esteem, and emotional development. The results indicated that sexually abused girls differed significantly from non-abused children in terms of their levels of depression, anxiety, and poor self-esteem. The results did not detect problems in terms of the girls’ ability to establish trusting relationships. However, in the absence of treatment negative symptoms were still present years after the abuse.

Young (1992) discussed symptoms and disorders that resulted from sexual abuse and related them to embodiment; how the self was experienced in and through the body. Based on her work with sexually abused children, the multiple effects of sexual abuse were: 1) eating disorders, 2) self-mutilation, 3) suicidal thoughts, attempts, and successful suicides, 4) drug and alcohol dependence, 5) multiple or borderline personality disorders,
6) sexual dysfunction or disinterest, 7) depression or anxiety, 8) rage, 9) poor self-esteem, 10) guilt, 11) social isolation, and 12) vulnerability to re-victimization. Young explained that children, and adults who were sexually abused, often developed a negative body image because abuse effects embodiment. Victims struggled to live with a body that they felt was damaged or dead, within a world that was dangerous and damaged. Dissociation occurred in children experiencing sexual abuse when they faced physical and psychological annihilation. They might “abandon the body, make it ‘outside me,’ pretend it doesn’t exist or turn on it in anger and confusion” (Young, 1992, p. 90). As part of dissociation, many victims learned how to induce anesthesia in different parts of their bodies while they were being abused or even after the abuse in response to stressful experiences. At first dissociation appeared to be involuntary and physically based, but post-abuse the ability of the victim to dissociate voluntarily became part of his or her personal identity. Child and adult victims of sexual abuse might display suicidal symptoms such as self-mutilation, suicidal thoughts, suicide attempts, or successful suicides. Young stated that suicidal actions resulted from the individual’s feeling that their body had betrayed them because it: 1) was small, weak, and vulnerable, 2) held pain and humiliation, or 3) felt some pleasure or release from the abuse.

Observations of affect in abused children were described in detail by Cattanach (1992) in *Play therapy with abused children*. Although children don’t appear to experience traumatic amnesia like adults, Cattanach stated that they do experience psychic numbing if exposed to chronic stress. A frozen, constant facial expression of watchfulness or hyper-vigilance might develop. Pseudo-mature behavior developed as a “false appearance of independence or being excessively ‘good’ all the time or offering
indiscriminant affection to any adult who takes an interest” (Cattanach, 1992, p. 25). Cattanach described disturbances in relationships and social skills in these children. They felt abandoned if they were taken from their families and didn’t understand what adults expected from them. They had difficulties in relationships because they experienced involved, sexual stimulation instead of parental affection and attention. Therefore, abused children tended to use sexual behaviors to make connections with others because it was the way they knew how to make friends. Sexually abused children were exposed to stimulation outside their level of physical or emotional development. When abuse was discovered, the shocked or disgusted responses of others toward this abuse confused children and caused them to assume they were dirty, disgusting, and to blame (Cattanach, 1992).

2.4.2 Foundational Treatment Methods

In addition to their literature on the effects of child sexual abuse, Sgroi (1982, 1988) and Porter et al. (1982) provided foundational literature on the treatment of sexually abused children. They stated that most children needed help overcoming the traumatic effects of their abuse. If immediate treatment could prevent the development of some destructive and dysfunctional behavior patterns, and address behavior patterns that already existed, eventually abused children would function better (Sgroi, 1982). According to Porter et al. (1982), intra-family sexual abuse of children should be treated with a combination of individual, group, dyad, and family therapy; however, they recognized that this was not always possible due to family dynamics. They believed that all children who were victims of sexual abuse should receive some type of therapeutic intervention, regardless of who was the abuser.
Dixen & Jenkins (1981) conducted a literature review of insight-oriented, behavioral, family, and marital therapies and also residential treatment as methods to treat victims of incest, their families, and abusers. Their literature review revealed the following trends: 1) behavior therapy was effective but had not been used to treat victims of incest, 2) family therapy seemed more successful when used after individual members were treated separately, 3) insight-oriented therapy was the only method used to address the long-term effects of incest, and 4) the most effective treatment might be a combination of different methods during the course of therapy. The wide range of foundational therapy methods used to treat sexually abused children included: 1) cognitive-behavioral therapy (Deblinger, McLeer & Henry, 1990), 2) group therapy (Kweller & Ray, 1992; Wolf, 1993), 3) psychoanalysis (McElroy & McElroy, 1989; Suffridge, 1991), 4) paraverbal therapy (multi-sensory therapy for children utilizing metaphors and different forms of communication such as visual, tactile, kinesthetic, and auditory) (Wheeler, 1987), 5) creative arts therapy (Harvey, 1990; Johnson, 1987), 6) group process combined with creative arts therapy (Powell & Faherty, 1990), and 7) play therapy (Cattanach, 1992; Harvey, 1990).

Gordon and Schroeder (1995) in *Sexuality: A developmental approach to problems*, suggested that the heterogeneous treatment needs of sexually abused children could be approached using a framework that helped to: 1) determine the importance of different contributing factors, 2) prioritize the focus of treatment, 3) select treatment procedures and techniques, and 4) evaluate the effectiveness of particular treatment methods. They main areas they addressed over the course of sexual abuse treatment for children were: 1) sexual education, 2) feelings and coping skills, and 3) personal safety.
skills. Gordon and Schroeder described how sexual education, with information about sexuality, helped children protect themselves and feel more powerful. It was important to first assess what the child already knew about sexuality. The therapist must remember that sexually abused children often had sexual experiences that were inappropriate for their age. They might require information that would typically be more appropriate for older children. Supportive caregivers should be informed about sexual information provided to a child. Gordon and Schroeder underscored a fundamental need to provide sexually abused children with skills to express and cope with their feelings before their sexual abuse was addressed and worked through in therapy. It was useful for sexually abused children to learn self-protection skills that could restore their sense of personal control and power. There were many age specific group and individual therapy techniques that taught children coping and self-protection skills and gave them an opportunity to practice these skills (Gordon & Schroeder, 1995).

Within the foundational research and literature, group therapy was specifically recommended for use with sexually abused children. Wolf (1993) studied group therapy with school aged girls who were sexually abused to determine successful techniques and structures. She found that within group therapy, the technique of interpreting and reframing behavior that resulted from sexual abuse was most successful. Wolf cited other literature including the work of Spruiell (as cited in Wolf, 1993) that described how group therapy for school aged children was successful because at this stage of development, peers and others outside of the family were becoming more important and children were beginning to be more aware of the behaviors of their peers. Sexually abused children often feel isolated from their peers because of traumatic experiences that
shaped their views of themselves and the world around them. If children with a history of sexual abuse were placed in a group with other abused children, it was theorized that their shared experiences would help them feel connected to others in the group.

Silovsky and Hembree-Kigin (1994) also addressed group therapy with sexually abused children. Grammer & Shannon (as cited in Silovsky & Hembree-Kigin, 1994) stated that in the initial phase of group therapy, it was crucial that therapists build a sense of trust to encourage more self-disclosure from group members. Once trust and group cohesion were established, the therapist initiated interventions to address more difficult issues that included: 1) guilt and responsibility, 2) reactions to disclosure of the abuse, 3) secrets, 4) court procedures, 5) sense of boundaries, 6) powerlessness, 7) self-protection, 8) sex education, 9) anger-control, 10) peer relations, 11) assertiveness, 12) anxiety, 13) depression, and 14) self-esteem. Many group therapists recommended using co-leaders for this population when addressing these issues. Silovsky & Hembree-Kigin (1994) suggested that beginning group therapy sessions with time for everyone to review their week might lead to discussion of abuse or trauma related themes. They explained that some group therapists don’t address abuse themes specifically but instead offer “normalizing” experiences (Carozza & Heirsteiner, as cited in Silovsky & Hembree-Kigin, 1994). Silovsky & Hembree-Kigin (1994) suggested that if it was relevant to the group, it was a good idea to discuss abandonment and separation. Incorporating a snack time modeled the importance of nurturance and gave an opportunity for socialization. In addition to discussions and snack time, group therapists selected structured activities to connect with the children’s presenting issues. A set structure for group therapy with this population helped reduce anxiety (Sturkie, as cited in Silovsky & Hembree-Kigin, 1994).
Other structured activities; such as role-playing, trust-building, making art, story telling and games; helped children address issues related to abuse and trauma in a less direct and overwhelming format. Throughout group therapy sessions, therapists could take advantage of any opportunities to teach coping skills and problem solving (Silovsky & Hembree-Kigin, 1994). Group therapy for non-offending caregivers was often recommended as part of the treatment of these children (Brady, as cited in Silovsky & Hembree-Kigin, 1994). Often non-offending caregivers experienced fear, anger, and feelings of responsibility that were similar to the emotional reactions of their children (Pescosolido & Petrella, as cited in Silovsky & Hembree-Kigin, 1994). Group therapy for caregivers increased their commitment to the treatment process and helped them both watch and prepare for changes in their children’s behaviors (Brady, as cited in Silovsky & Hembree-Kigin, 1994).

Several authors of foundational literature recommended play therapy with sexually abused children; it remains a treatment of choice. Cattanach (1992) described a multi-dimensional model of play therapy based on foundational aspects of play and its importance in helping children make sense of their world. Her play therapy model focused on helping children understand their abusive experiences and ultimately develop ways to function that did not recreate the patterns of abusive relationships. The four main concepts of this model were: 1) the centrality of play in helping the child understand his or her world, 2) play is a developmental process, in therapy children go back and forth along a continuum to discover individuation and separation, 3) play is a symbolic process that allows experimentation with imaginative choices in a safe way that distances children from real consequences of these choices outside of therapy, and 4) play happens
in a therapeutic space called the transitional space between the therapist and the child. Cattanach called this transitional space; “the space to define what is ‘me’ and ‘not me’, the place were our creative life starts, where we experience for the first time the psychological significance of art” (Cattanach, 1992, p.41). Children use play in different ways to contain their traumatic experiences. For some children play was a way to explore and make sense of their lives and experiences, while other children used play to feel safe in the present by containing the ‘monsters’ of their past (Cattanach, 1992). Cattanach organized play therapy for abused children in three ordered stages: 1) first--establish a trusting relationship between the child and therapist and create a safe place for exploration to occur through play, 2) second-- use toys, objects, and dramatic play in a focused way to explore, integrate, and clarify difficult issues in the past, and 3) finally--develop the child’s self-esteem and create an identity that isn’t as intertwined with abusive relationships. The play therapist contained the children’s play so that they could safely discharge and make sense of their abusive experiences.

2.5 Foundational Literature on the use of DMT with Victims of Trauma

The initiation of DMT research with victims of trauma in the 1980’s was based on limited foundational literature in all fields of therapy for this population. There was no foundational literature focused on the general treatment of traumatized children using DMT. Available literature specifically focused on children who were sexually abused, and adult survivors of either childhood sexual abuse or other forms of trauma. The literature prior to 1997 was summarized as it describes using DMT with these populations and provides a strong basis for therapeutic work during the past ten years.
2.5.1 DMT with Trauma Victims in General

2.5.1.1 Children

Numerous literature searches for foundational literature concerning the use of DMT with children who were victims of trauma in general were conducted but only one relevant research study was found. The research was a Master’s study done by Gonzalez (1993) to study the goals, methods, and techniques used by dance/movement therapists when working with children who had PTSD. Gonzalez interviewed five dance/movement therapists who worked with these children and asked them what they consider are effective goals, methods, and techniques. The main goals that were described in the interviews included: 1) forming a therapeutic alliance, 2) increasing self awareness and body awareness, and 3) increasing self-esteem. The goals were addressed in DMT by: 1) validating, labeling, and modeling feelings and behaviors, 2) expanding breath and movement repertoires, 3) creating clear limits and structure, and 4) helping children learn to master their environment. The common themes and issues that emerged from the interviews were: 1) the importance of building a therapeutic relationship through exploration of issues of boundaries, safety, and trust, 2) improve self-concept by providing praise and support, and reduce feelings of guilt, shame, and hopelessness, and 3) build a sense of empowerment by teaching children to use their weight and focus their energy to help them feel more in control.

Besides this single source, all literature was on DMT with children who had been victims of some form of abuse or maltreatment, or adult victims of trauma in general or childhood sexual abuse. Unlike researchers and clinicians outside of DMT that often grouped all information on children with abuse and other forms of trauma together,
dance/movement therapists chose to describe their work specifically with abused children. Therefore, it can be assumed that many of the treatment methods used in foundational DMT with abused children could also have been used for children who had experienced other forms of trauma.

2.5.1.2 Adults

Leventhal and Chang (1991) provided documentation of the success using DMT with adult victims of trauma; specifically battered women. Although their work did not focus on children or adult survivors of sexual abuse specifically, the information provided was relevant due to their strong focus on the body. Battered women suffered body level abuse similar to women and children who were sexually abused. Therefore, they had similar symptoms that required specific body level DMT interventions. The DMT techniques used by Leventhal and Chang addressed typical patterns of helplessness, ambivalence, and inactivity in this population and guided these women to internalize a positive self-concept and achieve physical and emotional control. They concluded that DMT provided focus on both physical and behavioral patterns that were indicative of the immobilization that was often present in battered women. Physical movement, with the therapist’s interventions, provided a challenge to psychophysical distortions in terms of the battered women’s physical characteristics and body image. Leventhal and Chang cited North (1972) who reported that improvements in self-concept and interpersonal dynamics could be created through expanding a person’s movement repertoire. Leventhal and Chang utilized this information in DMT with battered women who often became immobile as a coping strategy. In DMT, these women had the opportunity to explore their use of space, become active, and eventually become more physically
assertive. Dance/movement therapy techniques were used to encourage these women to both practice “freezing in place” physically, and also make changes in their breathing and muscle tone. Leventhal and Chang concluded that DMT provided opportunities for clients to experience creative dance, improvisation, and role-playing of feelings that supported safe exploration of affect.

Callaghan (1991) studied the advantages of using DMT with adults, living in exile, who were survivors of either physical or mental political torture. During this Master’s degree research, Callaghan detailed step by step procedures for conducting DMT therapy with these victims that could be applied to victims of other types of trauma. In a sense, a survivor of trauma or sexual abuse was a survivor of torture. Similar to battered women, victims of torture suffer many body level symptoms. Callaghan (1993) continued research with survivors of political torture and organized violence, and concluded that DMT empowered survivors to take control and responsibility for their bodies and psyche. Callaghan’s (1993) technique, called movement psychotherapy, helped affirm survivors in their bodies and move them forward in their healing process. Callaghan identified three areas of body involvement during torture and associated imprisonment: 1) it is used and destroyed through both physical pain and psychological humiliation, 2) there are physical damages, psychosomatic symptoms, and body image distortions, and 3) it is used for protection to reduce pain, exercised to keep control of their lives and show they were alive, and used to communicate non-verbally with other prisoners. Callaghan explained that unlike other forms of therapy, therapy and rehabilitation for survivors integrated both the body and mind. Torture caused people to return to preverbal stages of development and it was difficult for them to overcome
strong body memories of torture. During DMT, imagery, mirroring, and props (such as a stretch cloth), created support for the survivor to access his or her bodily memories and allowed them to express experiences that he or she couldn’t verbalize. Callahan (1993) cautioned that memories were accessed more quickly using the body than in verbal therapy so therapists needed to be careful that their clients were not overwhelmed.

2.5.2 DMT with Victims of Childhood Sexual Abuse

2.5.2.1 Children

Pioneering work by Goodill (1987) provided a strong foundation for the continued use of DMT with abused children. In this key article, Goodill discussed using DMT in the context of multi-disciplinary treatment of abused and neglected children. Goodill proposed that since abuse and neglect occurred first on a purely physical level, dance/movement therapists were “in a unique position to provide intervention and healing experiences” (Goodill, 1987, p. 61). In this article, DMT interventions were described that helped children to: 1) learn about safe touch to recreate a sense of control and ownership over their bodies and personal space, 2) more easily relate their experiences through nonverbal expression and using symbolism, and 3) become more assertive by using certain movements and movement qualities. Goodill explained that dance/movement therapists used the concepts of kinesphere to help children define and control their personal space and recreate a sense of control and ownership over their bodies. Movement activities; such as partner and group sculpturing, and imaginary body painting; involved safe, structured, and playful touching that emphasized that there were safe people. The non-verbal emphasis in DMT helped children to express memories about abusive experiences that were too painful or confusing to talk about or occurred at
a preverbal developmental stage. This therapy provided a format of movement, play, or mime to help abused children either tell stories about their feelings or connect memories, dreams and events either symbolically or literally. Goodill (1987) proposed that dance/movement therapy could be particularly helpful early in a treatment process when children were getting used to therapy and sharing very little verbally. She also recommended that treatment should include teaching children to: 1) be assertive, 2) speak out if something bothers them, and 3) be able to say “no”. Dance/movement therapy included movements and movement qualities that were connected to self-assertion. Teaching a broader range of movements gave the children more choices if they were threatened with abuse in the future. Goodill described several techniques used in DMT with this population. When dance/movement therapists led children to use strength in the lower half of their bodies and to move in space through the vertical plane (the space up/down and side to side), qualities associated with stability and confrontation, they developed a stronger sense of personal power and independence. Using strong rhythmic movement patterns and movement synchrony helped them develop strength and trust by re-experiencing the ego-building individuation stage. When children were able to be passive and strong they developed trust and could work to share more personal experiences with the therapist. The body/self image was strengthened by increasing body awareness, organizing body movement in space, and communicating about internal feelings. Creative movement tasks and imagery expanded the child’s awareness and creativity to aid in communication about their scary thoughts and emotions. Abused children knew the dangers of losing control. They needed to develop stronger impulse control and learned that they could be free and flexible but also in control. Improvisation
activities with a set closure gave children a chance to move freely while being provided with control and structure.

Weltman (1986), like Goodill, contributed vital information on using DMT with sexually abused children. Based on her DMT with sexually abused children, Weltman concluded that body movement was a child’s natural form of communication and expression. The non-verbal interactions that occurred in DMT helped these children “gain access to the ‘hidden’ experience and begin to process the physical movement and concomitant feelings and thoughts” (Weltman, 1986, p.53). Weltman believed that the goal for DMT was to: 1) build and recreate body integrity, 2) increase an awareness of power to regulate responses, and 3) gain a sense of control over how to respond to situations. In DMT, children could re-enact their abusive experiences in a safe way, release tension, express feelings, and expand on their thoughts and perceptions. Dance/movement therapists give a verbal message that it was okay to talk about sexual abuse, while also giving a non-verbal message to children that they were accepted and their feelings were contained. Weltman mentioned techniques similar to Goodill’s methods to help children experience safe touching that was not sexual in its meaning.

In addition to helping abused children create a sense of self-control and personal power, Weltman (1986) presented techniques for addressing body image issues. Weltman stated the unique contribution of dance/movement therapists was to help children create concrete experiences of both body awareness and personal and interactional space to restore their integrity on a body core level. Within movement therapy these basic and unique interventions brought a shift of power and control that empowered the children (Weltman, 1986). A child’s developmental level determined the
behavior and issues expressed in therapy. Weltman cited Peters (1976) who stated that healing occurred when a child was allowed to return to the actual day, time, and place of the abuse. Dance/movement therapy easily helped children reach this point as it naturally supported the process of going back to earlier stages in development. Weltman used a cloth to provide the self-directed movement that allowed children to return to earlier stages of development safely. The child was first wrapped in a cloth and then rocked and rolled to provide nurturing and reinforcement of body boundaries. The therapist moved with the child to provide support on a movement level.

Harvey (1995) published a DMT case study that described his work with a 3 ½ year old sexually abused child and her new foster-adoptive parents over 2 ½ years. The adoptive father was present for a few sessions but the main focus was on the relationship between daughter and adoptive mother. Harvey used movement, art, and play modalities and determined her inability to: 1) form a trusting relationship, 2) approach or stay focused on her adoptive mother, 3) take turns, and 4) maintain the same level of activity as her mother. Both the child and adoptive mother were unable to use shaping or matching of their bodies during interactions. During play activities, the mother and child were encouraged to create their own “land” using pillows. This physical separation increased their ability to mirror and respond to each other and prolonged their interactions for a longer duration without support. For homework, the mother was instructed to hold and rock the child in her lap; she was to strengthen her hold if the child resisted and relax her hold when the child relaxed. The child was taught to take deep breaths during these exercises while the mother touched her in a soothing manner. The goal was to help them become aware of both kinesthetic and touch cues through
responsive adjustment of their movement patterns with each other (Harvey, 1995). Once the child verbally disclosed her experiences of sexual abuse, already known to the parents and the therapist, she began to loose developmental abilities and act younger than her actual age. To address this issue, the therapist helped the child see her adoptive mother as a protective figure and developed more intimacy between them. When holding and rocking, the mother was asked to touch her daughter to recognize tension flow patterns (alternations in muscle tension creating patterns of movement) and if indicated, reassure her daughter that she was safe. Since closeness appeared to remind the child of her previous abuse, the therapist used props such as a stretch rope to connect the child and mother less directly as they moved. A stretch blanket was also used to cover their bodies so when one person moved it helped the other person move as well without actual touch.

The therapist encouraged the mother and daughter to create a dance to express their feelings when issues surfaced both during therapy and at home. Their dances evolved over time and allowed for safe emotional expression and a positive way for the two of them to interact (Harvey, 1995).

Several Master’s level research projects were focused on DMT with school aged children who were abused. LeMessurier (1990) reviewed literature on the effects and treatment methods for this population and described a case study using individual and group DMT with an 8-year-old girl who was sexually abused. In the literature review, LeMessurier included information from presentations made at the American Dance Therapy Association 1989 annual conference. For example, a presentation by Goldsand had described work with pre-adolescent sexually abused children. Goldsand observed that children were hesitant to acknowledge sexual abuse despite understanding it was the
purpose of their therapy. She empowered children by videotaping story dances they created that often had reoccurring themes of being chased by frightening creatures. The children danced for the camera and then watched themselves on television, which helped them develop self-concept and body image (Goldsand, as cited in LeMessurier, 1990).

Another presentation at the 1989 conference by Mewhinney described therapy with 4 to 14-year-olds in a short term hospital setting. The children had issues of low self-esteem, a lack of trust, repressed anger, no boundaries, and depression. She provided opportunities for these children to address feelings of powerlessness and re-enact their abuse in a safe environment. Mewhinney gave children choices during therapy sessions and used props such as a stretch band to create contained chaos and allowed them to build forts. Mewhinney stressed the need for the therapist to take the adult/parent role to prevent parental behavior in the children; such as a child trying to take over the group (Mewhinney as cited in LeMessurier, 1990).

LeMessurier (1990) conducted group therapy with seven girls, four were sexually abused. The goals were to: 1) create a positive body image and self-esteem through movement, 2) achieve control over impulses and expand movement repertoire, and 3) create group cohesiveness and the ability to work together. Structure was created by using set routines each week. All sessions started in a circle and each girl was asked to say her name while doing a movement that the rest of the group repeated. A movement warm-up followed, often to music. The therapist would first lead a movement and then each girl had a chance to be the leader. The main portion of the sessions included a variety of treatments structures that included: 1) partner interactions and trust-building exercises, 2) free movement using different props, or following movement suggestions
given by the therapist to elicit different Efforts (movement elements used to cope with changes in space, weight, and time), 3) imagery, particularly involving animals that the girls liked, 4) stop and go games to work on impulse control, 5) use of the stretch cloth to help the group learn to work together, make their bodies strong and grounded, and provide nurturance to each other, 6) exploring different types of boundaries through working with kinesphere, touching and shaping, 7) use movement to: interact with others, work through the pain of abuse, express oneself freely to improve self-esteem and work through abuse related feelings, and create empowerment through the body, 8) discuss issues of sexuality that arise out of movement, and 9) work on developing trust through creating a safe space and group support to override feelings of betrayal. The sessions closed with a circle while the girls ate a snack and engaged in a discussion. The group then passed a hand squeeze around the circle as closure.

Wegrzyn’s (1993) Master’s level research included a case study of DMT with a 9-year-old girl who had not disclosed but was suspected to have been sexually abused. The integrative nature of DMT allowed Wegrzyn to identify behaviors that were indicative of sexual abuse. Over the course of nine months, Wegrzyn followed a Chacian model in DMT sessions consisting of a warm-up, theme development, and closure. Based on the movement assessment, therapeutic goals were selected to: 1) establish trust and communication between the client and therapist, 2) achieve more verticality, 3) increase the ability to use strong weight to improve ego strength, self-esteem, independence from adults, and the ability to say no, 4) increase the level of concentration by increasing the use of Direct Space, 5) help the child express feelings clearly, and perhaps eventually disclose possible abuse, and 6) create clearer boundaries between self and others.
Wegrzyn worked to establish trust by creating a safe environment using techniques such as having her and the child choose pretend names for each other so the child could communicate in a distanced manner, and by mirroring the child’s actions and using verbalizations to help her be aware of her feelings. As the sessions continued, Wegrzyn observed underlying information and noticed themes that developed when the child initiated imaginary play with movement props. Wegrzyn periodically asked clarifying questions about the child’s play as well. In the final phase of the nine month treatment, various games were introduced to address the therapeutic goals. All games involved taking turns to differentiate between self and others. Stop and start activities supported increasing the child’s sense of time and sense of control. A significant amount of time in the final phase of therapy was used to prepare for termination of therapy. Preparation involved activities such as marking calendars to keep track of the number of sessions left and taking photos. Although no sexual abuse was ever disclosed, the therapy time gave the child a safe environment to work through and express her fears and worries. The opportunity to share unconscious thoughts with someone else, without losing support, appeared to help the child feel a degree of relief from the possible burden of keeping such a secret. The movement assessment at the end of the nine months showed improvements in body image, increased self-esteem, better relationship patterns, and more age appropriate sexual identity (Wegrzyn, 1993).

As a Master’s research study, Pupello (1996) implemented a model of DMT intervention to study the effects of an abusive environment on a child’s movement and how these effects could be treated successfully. Pupello speculated that children who grew up in an abusive environment developed certain movement characteristics that
negatively affected their ability to interact and relate to others. A therapeutic framework that combined movement, psychotherapy, and developmental theory was implemented in case studies with four children (two boys, two girls), ages 6½, 7½, 8, and 9, over the course of nine months, in either group or individual DMT sessions. Pupello recorded and described each child’s behavior in therapy, therapeutic processes that occurred, and interventions used. Pupello observed that the effects of abuse seen in these four children could be worked through successfully in DMT on non-verbal, physical and symbolic levels. Pupello reported that the most effective interventions allowed children to observe other children’s movement, acknowledge the connection between their feelings and movement, and later describe their movement experiences in words. This helped them connect their body experience to their feelings and aided mind-body integration. Pupello followed several guidelines and used interventions that included: 1) a structure of beginning, middle, and end phases for each session, 2) taking cues from the children’s movements, 3) creation of a safe place in the therapy room, 4) structured sessions to target hyperactivity and poor impulse control, 5) kinesthetic empathy and mirroring to make connections with children, 6) adjustment of goals and objectives for sessions based on thematic material produced by the children, 7) helping children use movement to express their feelings and strengths and allow them to start integrating and reclaiming their bodies, 8) assessment of the developmental level of each child using movement, to aid in the process of creating goals and interventions, 9) nurturance and empathy to help children engage in experiences that improve self-esteem and body image, 10) redefining body boundaries by providing tactile sensations, containment, and support, 11) opportunities for children to move with others to learn how to connect and interact
appropriately, 12) expanding children’s movement repertoire to aid in emotional
expression and use props for emotional release, and 13) use of creativity to communicate
on a symbolic level, embody desired characteristics, practice skills and behaviors, and
explore defense mechanisms. Pupello recommended long term, consistent interventions,
preferably continuing therapy longer than nine months, to allow for a stronger therapeutic
relationship to develop and help children learn to trust, interact, and communicate with
others. Pupello encouraged therapists to help children make connections between skills
learned in therapy and life experiences.

Two Master’s research studies focused specifically on DMT theories and methods
that were used to observe and assess sexually abused, school age children on a movement
level. Biggins (1989) conducted a literature based study on movements and other non-
verbal behaviors of 6 to 12-year-old, sexually abused girls. Based on this review,
Biggins summarized the expected movement characteristics of these children as: 1)
tension and little mobility in the pelvis, 2) fixation in infantile Effort and tension-flow
patterns, 3) problems using complex movement patterns, 4) difficulties in impulse control
and phrasing, 5) disturbed non-verbal communication; and 6) various characteristics
implying a damaged self-attitude. Biggins noted that these behaviors could also be due to
other family dynamics rather than sexual abuse. However, identification of these
movement patterns in a child should raise the possibility of abuse and precipitate a full
diagnostic investigation. In terms of therapy, these identified movement characteristics
created different insights into the child’s problems than the psychological indicators.
Biggins explained that movement patterns helped dance/movement therapists reduce the
amount of time needed to assess a child for possible abuse. Since movement was a good
indicator of a person’s coping mechanisms, it could be used in deciding the most appropriate treatment plan. There were no direct psychological “translations” of movement characteristics; therefore observation of movement patterns usually provided new information (Biggins, 1989, p.127). In another Master’s study, Brenner (1995) studied movement characteristics of non-traumatized, latency-aged children to compare with movement in children with a history of sexual abuse or other forms of trauma. The results indicated that movement characteristics in non-traumatized children differed significantly from movement observations of abused children described in earlier studies by Goodill (1987) and Weltman (1986). The results also supported use of Kestenberg’s latency-aged movement profile, a profile used by dance/movement therapists in their work with different clients.

2.5.2.2 Adult Survivors

There were many research studies on the use of DMT with adult survivors of childhood sexual abuse. Studies of DMT with adult survivors were included in this review to allow for a better understanding of the clinical treatment of abused children using DMT. Ambra (1995) interviewed five dance/movement therapists to gain information on their background, theoretical framework, therapy approaches, and the issues that they observed during their work with women who were incest survivors. The five therapists used some techniques with common characteristics and other methods that were unique to their own work. One therapist used Blanche Evan’s techniques (Bernstein, 1995) of insight oriented improvisation, creative dance, and movement education. The other four therapists used Authentic Movement in various combinations such as dyads and triads. Some therapists started sessions with a verbal check-in, while
one therapist used semi-directed movement with the client’s eyes open as a warm up. Overall, the DMT therapists explored issues of control, trust, and safety through a variety of movement methods. Their combined recommendations were: 1) allow clients to abstain from participation at any time they chose to, 2) help clients reach out to the group to connect, 3) encourage clients to trust their ability to tolerate and accept experiences of their bodies, and 4) use exercises to increase overall trust. During DMT sessions therapists defined the role of witness, clarified that the client was always in control, used a space for therapy that was private, maintained confidentiality, and kept boundaries for each session through set starting and ending times. The goals of their DMT sessions were to help clients: 1) improve their body image and self-esteem by establishing boundaries and kinesphere, 2) initiate grounding through various movement exercises such as breathing, 3) gain a feeling of having their feet connected to the floor, 4) feel the weight of their bodies, 5) use push and pull exercises to find their center, 6) learn to be more assertive and say no, and 7) use imagery to express memories and other feelings they couldn’t verbalize. An important technique used by one therapist was to increase the client’s improvisation skills, spontaneity, creativity, and movement repertoire to transfer experiences within DMT to her life outside of therapy (Ambra, 1995).

Bernstein (1995) described the theory and methods of a pioneer DMT therapist, Blanche Evan. The DMT methods that she developed during group and individual therapy with women who were victims of sexual abuse were called the Evan Approach. Evan’s approach was to restore a client’s natural potential for expressive movement and mobilize the interaction between her psyche and body. The Evan approach included dance education and movement rehabilitation, in-depth exploration of feelings, and
insight-oriented improvisation. Bernstein detailed the specific methods and theories of the Evan approach that were: 1) psycho-physical experiences, 2) mobilization to increase body awareness and broaden movement vocabulary, 3) improvisation, 4) functional techniques to focus on body mechanics, 5) ethnic dance, 6) use of creative dance to stimulate imagination, fantasy, and imagery, 7) language and vocalization as emotional expression, and 8) homework to bring skills and insight from therapy to the outside world. To successfully integrate the Evan approach, therapists must accept her underlying premise that a therapist’s support and encouragement can successfully lead a client through trauma towards health. Using the Evan approach, Bernstein watched and directed client’s movements from the sidelines, rather than moving with them, to encourage independence and discovery within the therapy techniques. Bernstein described DMT techniques to address common themes of shame, dissociation, body image issues, and guilt that arose during group and individual therapy sessions. For example, shame was addressed by helping the client loosen her body and explore new ways to move through space to reduce inhibitions. This movement led to discussions of stepping out in new ways in life and moving beyond the shame. A common theme with this population was their gaps in development caused by the abuse, family dynamics, and environments that allowed abuse to occur. Because survivors often grew up in constant fear, as adults they felt grief for their lost childhood. Dance/movement therapists addressed gaps in development through normal childhood experiences of play, imagery, and spontaneous movements. Survivor’s memories of feeling powerless, fearful, and lacking control had negatively affected their ability to form healthy relationships. DMT helped survivors identify with images of power and assertion to build a sense of strength
and control. To build actual muscle strength, Bernstein used a series of physical exercises, to work different muscles, called Functional Directives. Dance provided cathartic experiences that released unexpressed feelings and memories that were important in trauma resolution. The clients created their own dances to increase their assertiveness. The key in trauma resolution was the clients’ learning elements of dance including rhythm, space, dynamics, body movement, and content. Reenactments of confrontations with abusers and learning to turn rage outwards to their abuser, rather than inwards, also worked towards trauma resolution. Finally, a common result of sexual abuse was unconscious linking of body sensations with traumatic memories that caused disruptions in various elements of sexuality. Through dance, the “physicality of sex can be separated from the violence of sexual assault, the feeling of letting go separated from the act of giving in, being open separated from being exposed” (Bernstein, 1995, p. 56). Dance movement therapy helped abused women learn to separate these associations and therefore free their bodies and recognize healthy sexuality (Bernstein, 1995).

In a Master’s thesis, Spitzer (1990) described nine months of DMT therapy with a 26-year-old survivor of father-daughter incest. Spitzer used either mirroring or modification of her movement in response to the client, to give support, encouragement, and a positive non-verbal message of acceptance. This technique helped other survivors of incest who felt cut off from others and found it difficult to accept and trust anyone (Forward, as cited in Spitzer, 1990). Over time, Spitzer’s mirroring of the woman’s small, automatic movements increased her awareness and acceptance of her movements; an important step in acceptance of a part of herself. She became less nervous about moving but it took a long time for her to initiate authentic movements. Movement
activities were introduced to help her communicate. Whenever the client seemed overwhelmed and reluctant to move, the therapist simply mirrored her position, and tried to give the message that she was there for her in this painful and confusing time. Spitzer described how the client had difficulty expressing strong feelings, thoughts, and fears evoked in therapy. The improvements observed in this client, through the course of therapy, supported using DMT with survivors of father-daughter incest (Spitzer, 1990).

Chess (1989) conducted a phenomenological study to better understand the experiences of pre-verbal sexual trauma in four women through non-verbal methods. The study consisted of one pre-interview, a five hour DMT workshop, and two follow-up interviews. The five hour workshop consisted of structures that included: 1) movement activities to increase body awareness, allow for expression, and build empowerment, 2) using a stretch cloth to encourage free explorative movement and interactions, and 3) guided imagery and visualization exercises that helped participants focus on particular aspects of themselves, such as a physical symptom or body part or imagining the nurturing experience of being rocked by a caregiver. The themes that emerged in the participants’ descriptions of their experience were that they: 1) found validation for aspects of their traumatic experiences, 2) were challenged by finding trust in the face of childhood sexual abuse issues, 3) had memories of traumatic childhood events triggered by movement therapy and imagery tasks, 4) experienced success using body-oriented methods to create memory and insight, 5) had positive effects from the workshop expand beyond the end of the study, 6) felt mutuality in the participant-researcher/therapist relationship that shaped the experience of the workshop, and 7) believed that the workshop was a catalyst for emotional integration and healing.
A multi-model therapy method was developed by Simonds (1992) for use in body image groups for women survivors of childhood sexual abuse. In the groups clients were asked to: 1) make a list of words to describe what they felt about their bodies, 2) draw a self-portrait, 3) listen to guided imagery and choose a positive word, 4) create a movement or posture and choose music that reflects this positive word, and 5) show their movement or posture to the group, 6) lead the group in their movement or posture, and talk about what was done. Simonds designed the body image groups with structured activities to support the development of a theme and encourage discussion. In the discussion period, each person identified positive body and personality attributes of other members. The members were expected to listen to compliments quietly without a response. Simonds stated that the group structure allowed for spontaneous discussions of childhood sexual abuse at each person’s comfort level. The degree that sexual abuse was discussed depended on how much the individual had worked through their abuse experience. Comfort with feelings of sexuality and femininity were dependent on healing from the abuse. According to Simonds, treatment to integrate a positive body image took a long time and required that a woman felt comfortable in her sexuality.

2.6 Recent Knowledge on the General Effects of Trauma on Children

The following sections describe the literature concerning effects and symptoms that result from trauma of children. This section includes a specific focus on research concerning neurological effects of trauma and the effects of trauma on the body.

2.6.1 General Effects of Trauma

2.6.1.1 Symptoms Resulting from Trauma
Cook et al. (2005) conducted a comprehensive literature review on complex trauma. They described seven main areas of impairment in traumatized children: 1) attachment, 2) biology, 3) affect regulation, 4) dissociation (i.e. alterations in consciousness), 5) behavioral regulation, 6) cognition, and 7) self-concept. If trauma occurred in a parent-child relationship, children often developed insecure attachment patterns, the most damaging form being disorganized attachment. Problems in attachment patterns caused life long risks of physical disease and psychosocial problems.

In terms of biology, information in the literature confirmed that children with traumatic histories were at risk for developmental arrest of brain functions needed to modulate emotions in response to stress. When faced with stress, the difficulties traumatized children had analyzing a situation led to cognitive, emotional, and behavioral disorganization. They were prone to react with severe helplessness, confusion, withdrawal or rage. Traumatized children often developed affect regulation problems that were reflected in their inability to correctly identify internal emotional experiences, express emotions in a safe way, and modulate or regulate internal experiences. Instead, this population used dissociation to cope with their traumatic experiences. When the traumatic exposure was chronic, the child often relied on dissociation and experienced difficulty with self-concept, managing behavior, and regulating affect. Traumatized children also often had difficulty soothing themselves. Adaptation through dissociation helped cause “automatization of behavior, compartmentalization of painful memories and feelings, and detachment from awareness of emotions and self” (Cook et al., 2005, p.394). Both uncontrolled and over-controlled behavior patterns developed in traumatized children as a result of the re-enactment of specific aspects of traumatic
experiences. Using either type of control allowed the children to develop a sense of mastery over reenactments and their behaviors, and avoid intolerable levels of emotional arousal. Complex trauma exposure led to cognitive impairments that interfered with skills for self-regulation as early as late infancy. By early childhood, these children showed less flexibility and creativity in problem-solving tasks. By early elementary school age, they were often referred for special education services. Traumatized children often had a negative self-concept and tended to react to verbal recognition and praise for positive actions with neutral or negative affect. Their negative experiences led them to sense themselves as defective, helpless, deficient, and unlovable. The result was they blamed themselves for their negative experiences and had trouble getting and accepting outside support. Complex trauma exposure led to loss of important skills that supported interpersonal relations (Cook et al., 2005).

Bannister (2002) addressed the effects of trauma in children on their development and used action methods based on the concept that mind and body were closely connected. Dissociation was described as a protective mechanism that led traumatized children to feel separate or cut off from their bodies. While dissociation helped children feel more in control of their feelings (Shirar, as cited in Bannister, 2002), sexual abuse victims had somatic symptoms from excessive use of dissociation to disown complex feelings that were too overpowering to handle. Like Cook et al. (2005), Bannister discussed the negative effect trauma had on the process of attachment and how it started affecting children’s development in infancy. The fragmentation of the child’s sense of self made it difficult to them to form an integrated identity.
Hutchison (2005) wrote about both the effects and treatment of childhood trauma. She discussed development of insecure attachment patterns in traumatized children and how the patterns affected their development and created identity problems. The effects of trauma on development, described in terms of Erikson’s stages of development (as cited in Hutchison, 2005), were: 1) an overwhelming sense of mistrust of the world and others, 2) failure to achieve a sense of autonomy, 3) doubt of their independence and abilities, 4) no strong sense of self and of their body, 5) doubt their own sense of judgment, 6) guilt about thoughts, fantasies, and actions, 7) reversion to less advanced stages of development and difficulty using newly mastered skills that made them feel inferior to peers, and 8) identification with aggressor or being forced to take on an adult role that caused confusion. In addition, problems with memory development were present in traumatized children that differed depending on the child’s age. All children had anxieties and fears, often due to their active imaginations, that tended to dissipate as they matured. However, traumatized children were constantly anxious with fearful reminders of their traumatic experiences and frequently showed separation anxiety and stranger anxiety. The only imagined fears of most children were actualized in traumatized children whose fears were overwhelming and they worried about re-occurrence of the traumatic experience. Other effects of trauma on children’s development included: 1) increase in anger and aggression, 2) depression, 3) school related issues such as issues of overall performance and discipline, 4) irritability, 5) hyper-vigilance, 6) sleep disturbances such as nightmares, intrusive thoughts, images, and sounds, 7) restricted affective experiencing or emotional numbing, 8) reenacting of the traumatic incident, 9) insecurity, 10) fear in general and fear of further trauma, 11) guilt, 12) reduced impulse
control, 13) intrusive thoughts/reliving of traumatic memories, 14) separation anxiety or overanxious disorder, 15) age inappropriate behavior such as whining, clinging, and temper tantrums 16) problems with trust, and 17) risk of future sexual promiscuity, unsafe sex practices, and alcohol and drug use (Hutchison, 2005).

More recent work of Streeck-Fischer and van der Kolk (2000) and van der Kolk (2003) summarized the effects of trauma on individuals of all ages. The wide variation in effects were: 1) dissociation, 2) depression, 3) PTSD, 4) suicidal tendencies and risk of future suicide attempts, 5) separation anxiety/overanxious disorder, 6) phobic disorder, 7) attention deficit hyperactive disorder (ADHD), 8) oppositional defiant disorder (ODD), and 9) conduct disorder. Traumatized children often had difficulty controlling their emotional responses and modulating their behavior. Despite this struggle they tried to stabilize their emotional lives through emotional constriction and avoidance; often seen through their disassociative symptoms. According to Streeck-Fischer & van der Kolk (2000), the children’s awareness of this lack of control caused them to hate themselves and they often responded by self-medicating with drugs, food restriction and/or bingeing, or other self-injurious behaviors. In more extreme cases, some traumatized children developed a form of dissociation where they dealt with stress by splitting their personality into different entities. This split made the child unable to integrate different states of emotional engagement and he or she felt like different people at different times. The inability of children to distinguish between relevant and irrelevant information, and their fear of unexpected and novel stimuli and information, caused various learning difficulties, especially attention disorders. They often had auditory and visual perceptual problems. These children were “easily overstimulated and cannot achieve the state of
secure readiness that was necessary to be open to new information” (Streeck-Fischer & van der Kolk, 2000, p.912). Traumatized children experienced the world as a scary place. Taking risks and being curious was very difficult for them. When placed in stressful situations, traumatized children often returned to earlier developmental levels or took on different ego states that ranged from infantile to near psychotic to hyper-mature states. Healthy children had freedom to be imaginative and play while traumatized children were often so preoccupied with keeping themselves safe that they were not playful and did not use their imagination to interact with the outside world. Overall, difficulties observed during their play were: 1) rigid and constricted play with constant repetition of topics with no changes over time, 2) distress and helplessness instead of mastery and pleasure, and 3) ambiguous or affectively charged stimuli in play as if they were in a traumatic situation. Finally traumatized children showed neurobiological dysregulation as an effect of their experiences with possible long term effects of: 1) loss of self-regulation including emotional regulation, 2) problems with self-definition, 3) learning and memory issues caused by hyper vigilance and skewed perceptions of the world, 4) social problems due to difficulties reading social cues and adapting arousal levels, 5) drug abuse and self-mutilation, 6) violent and aggressive behavior towards others, and 7) physical conditions including cancer, heart disease, and diabetes, (Streeck-Fischer & van der Kolk, 2000; van der Kolk, 2003).

Various other literature sources mentioned effects of trauma on children that included: 1) medical and other health problems (Feather & Ronan, 2006), 2) low self-esteem, (Moore, Armsden & Gogerty, 1998), and 3) acute stress disorder and PTSD (Cohen, 2003). Ogden, Pain, and Fisher (2006) described additional symptoms that were
mainly bodily responses to dysregulated affect. The symptoms often observed in traumatized children met the diagnostic criteria for: 1) mood disorders, 2) anxiety disorders, 3) substance abuse and dependence disorders, 3) eating disorders, 4) somatoform disorders, and 5) medically unexplainable symptoms.

2.6.1.2 Neuroscience Research on Effects

There is a more recent, comprehensive, body of research that specifically describes the neurological effects of trauma. Understanding the neurobiological basis of a trauma response is pertinent to the treatment of trauma. However, it was beyond the scope of this study to fully review this vast field of literature. This section provides an overview of the neurobiology of trauma from the perspective of van der Kolk (1999), Kendall-Tackett (2000), and Perry (2006). Much of their research focused on people who developed PTSD after experiencing trauma. It is assumed that this research is relevant to people who have experienced traumatic events but have not developed PTSD.

van der Kolk, a pioneering leader in neuroscience research, investigated the effects of trauma and applied his understanding to development of trauma treatment methods. van der Kolk (1999) published on effects of posttraumatic stress on the body and memory. He stated that the emotional impact of a traumatic experience might interfere with a person’s ability to capture this experience in words or symbols. According to Piaget (as cited in van der Kolk, 1999), this interference led to: 1) storage of memories on a somatosensory or iconic level in somatic sensations, 2) behavioral enactments, 3) nightmares, and 4) flashbacks. A constant high level of arousal caused the primitive areas of the brain, limbic system, and brain stem to generate sensations and emotions that contradicted conscious beliefs and knowledge (van der Kolk, 1999). A
hyper-aroused person might respond with irrational behavior to stimuli that were in fact neutral or just stressful, rather than traumatic. The amygdala section of the brain interprets the threat of incoming sensory information and was central to creating traumatic re-experiencing. The amygdala stored emotional memories from specific sensations, sounds, and images related to threatening situations. In a traumatized person, these memories became set so that when specific sensations were re-experienced, regardless of the actual situation, the person was likely to respond with flight or fight reactions (van der Kolk, 1999). Kolb (as cited in van der Kolk, 1999) was the first researcher to suggest that negative effects on learning habituation and stimulus discrimination could occur following excessive stimulation of the central nervous system (CNS) during a traumatic event. The acoustic startle response (ASR) is a cascade of muscular and autonomic responses that are stimulated by sudden and intense stimuli that often appeared abnormal in those suffering from PTSD (Shalev Rogel-Fuchs, as cited in van der Kolk, 1999). A healthy person could habituate to ASR after 3-5 presentations of the stimuli. People with PTSD showed a failure to habituate to ASR through both the CNS and mediated responses of the autonomic nervous system (van der Kolk, 1999).

Streeck-Fischer and van der Kolk (2000) stated that childhood trauma, especially chronic trauma, had negative effects on child development. Interference with integration of sensory, emotional, and cognitive information into a cohesive whole, led to the child’s unfocused and irrelevant responses to future stress. Traumatized children suffered developmental delays in cognition, language, motor and socialization skills (Culpe, Little, Letts & Lawrence, as cited in Streeck-Fischer & van der Kolk, 2000).
According to van der Kolk (2002), people most directly exposed to the sensory stimuli of traumatic events were at highest risk for developing psychological problems. van der Kolk summarized numerous studies, including his work with McFarlane and Weisaeth that confirmed individuals with PTSD experienced psychophysiological reactions and neuroendocrine responses when they were in contact with stimuli from the original trauma (van der Kolk, McFarlane & Weisaeth, as cited in van der Kolk, 2002). This indicated that traumatized individuals developed a conditioned response to certain reminders of the trauma. This conditioned response initiated a flight or fight biological response as if the person were experiencing the traumatic event again. Other studies found that people with PTSD developed abnormalities in the neurotransmitters that regulated arousal and attention. Generally, stress activated two stress hormones, the catecholamines and cortisol, but people with PTSD had low levels of cortisol (van der Kolk, 2002). When low levels of cortisol were combined with increased levels of norepinephrine, the individual became more reactive to arousing stimuli. Individuals with PTSD experienced indiscriminate flight or fight reactions (Yehuda, as cited in van der Kolk, 2002). Arnsten (as cited in van der Kolk, 2002) conducted research on brain reactions to various challenges and documented that the frontal areas of the brain were deactivated when people were frightened or aroused. The frontal areas of the brain are responsible for analyzing experiences and associating them with other stored knowledge. The deactivation of the dorsolateral prefrontal cortex, the site of executive functioning, interfered with their ability to have a specific measured response to a threat. Also, high levels of arousal interfered with the functioning of Broca’s area of the brain that transfers
feelings into words (Rauch et al., as cited in van der Kolk, 2002). They explained that this
deactivation made it difficult for victims of trauma to verbally express how they felt.

van der Kolk’s (2003) research on neurobiological effects of childhood trauma
and abuse explained how PTSD impacted three interrelated developmental pathways by:
1) the maturation of specific brain structures at specific ages, 2) physiological and
neuroendocrinologic responses, and 3) the capacity to coordinate cognition, emotion
regulation, and behavior. Traumatic experiences affected children differently depending
on their age and stage of development. As children developed, their brains continuously
organized and internalized new information. Children who were continuously exposed to
trauma or were continually in a hyper-aroused or detached state had a reduced ability to
deal with stress and altered development. The neurobiologic disruptions caused by
trauma affected the development of brain areas responsible for: 1) regulation of
homeostasis, 2) executive functioning, and 3) memory systems. Trauma also affected the
neuroendocrine system (van der Kolk, 2003).

Kendall-Tackett (2000) reviewed literature on the effects of trauma on the brain
and presented neurobiological symptoms of trauma. Like van der Kolk, Kendall-Tackett
discussed the discovery that people with PTSD had abnormally low levels of cortisol and
abnormally high levels of norepinephrine (Yehuda, 1999; Yehuda et al., as cited in
Kendall-Tackett, 2000). Some research results demonstrated that people with PTSD
appeared to have a dysregulated stress response. Instead of a coordinated stress response,
in which cortisol and norepinephrine operated together, in PTSD they operated separately
(Bremner, as cited in Kendall-Tackett, 2000). A review by Yehuda (1999), presented by
Kendall-Tackett (2000), stated that trauma survivors with PTSD could be hypersensitive
to environmental and external events, and might become hyper-aroused and respond accordingly even when the event or stimuli was neutral.

Perry (2006) stated that it is important to understand brain development and functioning to understand the abnormal functioning that occurred in people after they experienced abuse and trauma. Treating children with abuse experiences can change brain function and restore healthy function but it is dependent on the type, timing, and length of treatment. Perry, along with his colleagues, created a neurosequential model of therapeutics (NMT). The six key principles of neurodevelopment and neurobiology that provided the rationale for NMT were (followed by an example in parentheses): 1) the brain has hierarchical organization; all sensory input first enters the lower parts of the brain and eventually reaches the neocortex (If a pattern was novel, or matched with a previous pattern associated with threat, the body triggers an alarm response and internal state of arousal that moves up through each part of the brain causing neural activity), 2) neurons and neural systems are designed to change in a “use-dependent” fashion (The symptoms a traumatized child displays are directly related to a history of neural activation or lack of activation. If a child was neglected, he or she will have deficits in the areas where the neglect specifically occurred), 3) the brain develops in a sequential pattern (Stress responses originate in the lower parts of the brain and if damage to these parts occurs, stress dysregulates and disorganizes higher parts of the brain), 4) the brain develops most rapidly early in life (Children are more vulnerable to trauma than adolescents or adults; the younger the child is the more enduring and pervasive issues that develop), 5) neural systems can be changed, however, some systems are easier to change than others (Once an area of the brain was organized it was less able to change but some
parts of the brain such as the cortex stay significantly plastic throughout life), and 6) the human brain was designed for a different world, (Brains prefer past environments to the current over stimulating, distracting, and relationally deprived environment). Based on these principles, Perry also explained the clinical implications of each of the six principles and outlined critical treatment guidelines.

2.6.1.3 Trauma Effects on the Body

It is agreed by many researchers that traumatic events impact the body and the mind, even when there is no direct bodily harm. Rothschild (2000) explained that traumatized people, especially those who suffered abuse, are often overwhelmed or “go dead” in their bodies when they are touched. Even touch by a safe and caring therapist can trigger memories of traumatic events. The client might transferentially perceive the therapist as the perpetrator. The hyper-arousal experienced by traumatized people created sensitivity to everything (Rothschild, 2002). The traumatized individual often was humiliated by loss of control over bodily functions. Traumatic events were stored as implicit, unconscious memories that consisted of emotions, sensations, movements, and automatic procedures. These memories, often expressed in biological stress responses, were called “body memories” or “somatic memories” because they were stored and remembered through an inter-communication between the brain and the body’s nervous system (Rothschild, 2002; van der Kolk, 1999). Sometimes traumatic memories were comprised of body sensations with little cognitive processing to help the individual make sense of the memories (Rothschild, 2002). In foundational literature, Herman (1992) explained that traumatic experiences “violate the autonomy of the person at the level of basic bodily integrity. The body is invaded, injured, defiled” (Herman, 1992, p. 53).
van der Kolk (1999) suggested that traumatized individuals with PTSD experienced a heightened physiological arousal to sounds, images, and thoughts that were connected to traumatic experiences. Research results indicated that these individuals had conditioned autonomic responses to trauma related stimuli that included increased heart rate, skin conductance, and increased blood pressure (van der Kolk, 1999). Intense responses could occur years and even decades after the trauma occurred; traumatic memories could powerfully and continuously affect a person’s life (van der Kolk, 1999).

Truppi (2001) conducted DMT research with adolescent girl victims of sexual abuse and concluded that violation of their bodies significantly affected both their bodies and psyche. Sexual abuse had significant negative effects on their body image and they persistently experienced their bodies as dirty and shameful. This damage to body image was exhibited through body rigidity and somatization. Eating disorders and self-mutilation appeared to serve as maladaptive coping responses in these abuse victims; however, the purpose of these behaviors varied from person to person (Truppi, 2001).

According to Streeck-Fischer and van der Kolk (2000) as children grew they developed self-awareness and self-regulation by learning to understand the meaning and importance of physical sensations. People interpreted the meaning of experiences through physical sensations that were evoked and the learned meaning of these sensations. Traumatized children were unable to process and understand physical sensations as were needed to appropriately respond. This inability affected body functioning and pain perception; caused problems with coordination, balance, and body tone; and could result in disorientation in space and time. Some traumatized children
responded to stress by freezing in set body positions; others coped using withdrawal and avoidance or using sensorimotor constriction (Streeck-Fischer & van der Kolk, 2000).

Kendall-Tackett’s (2000) literature review revealed that an important body level effect of childhood abuse was irritable bowel syndrome (IBS). Irritable bowel syndrome is a disorder of the lower gastrointestinal tract with symptoms of abdominal pain or cramping, diarrhea or constipation, and bloating or abdominal distention. Often IBS is diagnosed after all possible causes of the symptoms are excluded. It is suspected that IBS results from hyper-arousal and a concentration on pain. Pain has a strong mind-body component that provides support for the connection between IBS and childhood abuse. The American Gastroenterological Association identified “a history of physical or sexual abuse as having a ‘strong effect’ on the outcome of treatment for IBS” (The American Gastroenterological Association, as cited in Kendall-Tackett, 2000, p. 803).

### 2.6.2 Specific Effects of Childhood Sexual Abuse

Sexual abuse often has similar effects in children as other forms of trauma but the impact becomes more severe based on the following variables: 1) longer duration and higher frequency, 2) multiple perpetrators, 3) presence of penetration or intercourse, 4) physically forced sexual contact, 5) abuse at earlier age, 6) molestation by a perpetrator substantially older than the victim, 7) concurrent physical abuse, 8) abuse with bizarre features, 9) victim’s immediate sense of personal responsibility for the molester, 10) feelings of powerlessness, and 11) betrayal (Gil, 2003). There doesn’t appear to be a distinct, identifiable syndrome that results from sexual abuse, instead each abused individual has a unique combination of symptoms (Ross & O’Carroll, 2004; Truppi, 2001). The effects of sexual abuse vary across the developmental spectrum (Ross &
O’Carroll, 2004) and the effect of sexual abuse on a child’s development depends on his or her age during the abuse. Despite the increased interest, concern, and research on the effects of child sexual abuse, objective research data on the topic is lacking. Childhood sexual abuse (CSA) is associated with numerous psychiatric issues that can be long lasting and inflicted significant functional impairment (Cohen, 2005). Early traumatic experiences, particularly sexual abuse, affect many aspects of the child’s development and causes problems throughout life (Bannister, 2003). It appears that younger children often show more physical symptoms, while older children, who are probably abused for a longer time, have numerous problems that they can hide using more developed coping skills (Bannister, as cited in Bannister, 2003).

Specific effects of CSA were presented by Gil (2003) within a description of art and play therapy techniques and their use with sexually abused children. The wide range of effects of sexual abuse described by Gil included: 1) post traumatic stress and PTSD, 2) altered emotionality due to the dysregulation effect of the trauma, 3) disassociative symptoms, 4) eating disorders, 5) fear, 6) anxiety, 7) aggression, particularly sexual aggression, 8) poor self-esteem, 9) academic difficulties, 10) issues concerning the development of the self and healthy attachments to others, 11) sleep disturbances, 12) behavior problems such as behavioral dysregulation, 13) cognitive distortions, and 14) damage to their relationships with adults and peers. Gil emphasized that each abused child had a unique presentation of symptoms based on different experiences, his or her interpretation of these experiences, and the original defensive strategies he or she developed to cope and survive these painful events.
An understanding of the effects of sexual abuse on children was enhanced by Scott, Burlingame, Starling, Porter and Lily (2003) who described client-centered play therapy with this population. Scott et al. (2003) listed the following results of sexual abuse: 1) drug and alcohol abuse, 2) fears related to the abuse, 3) anger, aggression, or hostility, 4) guilt and shame, 5) poor self-esteem or poor self-concept, 6) anti-social behavior such as stealing, tantrums, and delinquency, 7) cognitive distortions, 8) mood disturbances, 9) sexual identity problems, and 10) somatic issues. Social isolation issues in this population resulted from inappropriate acting out sexually and withdrawing into fantasy to avoid reminders of the abuse or possible re-traumatization (Scott et al., 2003).

Deblinger, Stauffer & Steer (2001) described the effects of sexual abuse by comparing supportive and cognitive behavioral therapies for both young children who were sexually abused and their non-offending mothers. Again, very similar effects that were reported for this population were: 1) posttraumatic stress, 2) age-inappropriate sexual behaviors, 3) depression, 4) fears related to abuse, anger, guilt and shame, 5) sleep disturbances, 6) hostility, and 7) behavior problems. Although sexually abused children might show few negative effects initially, they might over time, even when the abuse has stopped, develop similar effects as they gain a better understanding of their experiences (Deblinger et al., 2001).

Bannister (2003) was a leader in applying creative arts therapies to treating traumatized children. As background, she explained how discussion of sexual topics is discouraged in many cultures. Children are discouraged from talking about it and have to cope and adapt to their abuse. This adaptive behavior becomes a part of the child’s personality and is often not recognized as a problem until later in his or her development.
when more problems arise. Bannister observed that abused children often developed a
disorganized pattern of attachment because they saw themselves as helpless, angry, and
unworthy. They might see their caregivers as scary, or sometimes their caregivers
seemed scared as well (Bagley & Thurston, as cited in Bannister, 2003). If children were
abused by a caregiver and they could not believe their caregiver was bad, they reversed
their thoughts and saw themselves as bad and their abuser as good (Bannister, 2003).
This attachment style and the underlying beliefs caused problems in relationships.
Sexual abusers also damaged a child’s attachment process by building and strengthening
their attachment to the child while they tried to destroy the child’s attachment
relationships with non-abusing adults (Bagley & Thurston, as cited in Bannister, 2003).
Instead of learning about their autonomy and individuality, sexually abused children
learned to interpret and meet the demands of their abuser (Atwood & Donheiser, 1997).
They tried to survive both physically and psychologically, but if abuse continued they
eventually developed a “false self” with no distinction between their psychological self
and that of the abuser. The “false self” was developed to satisfy the abuser’s needs and
receive love from them. The abused child suppressed his or her true self out of fear that
it would upset the abuser and cause more abuse (Atwood & Donheiser, 1997, p.196).

Powell (1996) summarized research studies on effects of sexual abuse on child
development. Abused children had trouble completing the Erikson (1963) stages of
psychosocial development (Bowlby, as cited in Powell, 1996). When children lived in
incestuous relationships at home, the inconsistent roles of family members caused them
difficulty completing stages of their development. This environment created role
confusion, social isolation, inappropriate boundaries, and reduction in the child’s ability
to interpret social cues from his or her environment. Children who experienced traumatic sexualization or developed inappropriate sexual attitudes felt betrayed when they realized people they should have been able to trust had abused them. These children developed a sense of powerlessness when they tried unsuccessfully to stop the abuse. They eventually reached a point of stigmatization when their internal feelings of badness, shame, and guilt that developed during abuse, became an active part of their self image (Powell, 1996).

Truppi (2001) summarized the attitudes and confusions of sexually abused adolescent girls living in a residential treatment facility. During DMT the children expressed or indicated in some way that they felt: 1) they were different from their peers, 2) responsible for negative events (they should have tried to prevent the abuse or disclosed the abuse earlier), 3) a lack of interpersonal trust, and 4) lowered credibility. Their negative self-perception led to: 1) sexual identity and other sexual problems and sexual compulsivity, 2) somatization, 3) self-mutilation, 4) risk of suicide, 5) obsessions/compulsions, and 6) disassociative identity disorder.

Briscoe-Smith and Hinshaw (2006) conducted research to determine whether there was a connection between attention-deficit/hyperactivity disorder (ADHD) and abuse in girls. The researchers compared diverse samples of girls ages 6-12, 140 with and 88 without ADHD, to detect rates of physical and sexual abuse in each sample. There were significantly higher rates (14.3%) of abuse in girls with ADHD than in the comparison sample of girls without ADHD (4.5%). Specifically, most abuse was detected in girls with ADHD combined type. In addition, the results demonstrated that girls with ADHD and a history of abuse were unique in terms of their level of externalizing behavior and peer rejection from other children who only had ADHD. The
abused girls were described as being significantly more aggressive and they experienced more social rejection. The researchers found that peer rejection was mediated to some degree by their high rates of aggressive behavior.

Chaffin, Wherry and Dykman (1997) conducted a descriptive study using standardized scales to investigate the coping strategies in a group of 84 sexually abused children, ages 7 to 12, to cope with their abuse. The most common coping strategies were labeled as: 1) avoidant, 2) internalized, 3) angry, and 4) active/social coping. Each of the coping strategies was linked to a unique set of abuse characteristics and abuse-related environmental characteristics, in addition to a unique set of abuse-related or behavioral symptoms.

Kaplow, Hall, Koenen, Dodge and Amaya-Jackson (2008) conducted a quantitative study to create and test a prospective model of attention problems in sexually abused children and to determine if dissociation determined later attention problems. A path analysis revealed two direct paths that led to attention problems: the child’s relationship to the perpetrator, and dissociation measured directly after disclosure. These two pathways accounted for 52% of the variance in attention problems. The researchers concluded that children who either reported disassociative symptoms after disclosing sexual abuse and/or were sexually abused by a member of their family were at an increased risk of developing attention problems.

Taylor (2002) conducted a literature review study to examine recent research on the social and emotional outcomes of childhood sexual abuse. The symptoms that were most commonly mentioned were divided into three developmental periods: 1) early childhood— inappropriate sexual behavior, internalizing, externalizing, 2) middle
childhood—depression, suicidal ideation, PTSD, sexual anxiety, inappropriate sexual behavior, internalizing, externalizing, and 3) adolescence—risky sexual behavior, depression, suicidal thoughts, suicide, internalizing (low self-esteem), PTSD, externalizing (anti-social behavior), substance use, gang involvement, pregnancy, running away. Taylor provided multiple citations for each individual symptom.

Kordich Hall, Matthews, and Pearce (2002) developed an empirically derived typology for sexually abused children with sexual behavior problems to help therapists with assessment, treatment, and case planning. The researchers systematically gathered data from client files and created twelve indices corresponding to child and family history, functioning, and response to treatment. The cases were divided into subgroups based on the presence or absence of sexual behaviors. Analysis of the cases revealed five different sexual behavior profiles: 1) Type 1-- Developmentally “expected” sexual behavior- children who do not show problems with developmental level of sexual behavior, and experience pain and discomfort during abuse but are not sexually aroused, 2) Type 2-- Unplanned, interpersonal sexual behavior (developmentally problematic) - children exhibit problematic, interpersonal, sexual behavior that is spontaneous, episodic, and not entrenched; they experience pain and discomfort during abuse but are not sexually aroused, 3) Type 3-- Self-focused sexual behavior (developmentally problematic) - children who display frequent and compulsive masturbation and sexual preoccupation, few sexualized gestures, have no problematic interpersonal sexual behavior, and experience little pain and discomfort but abuse leads to more sexual arousal, 4) Type 4-- Planned, interpersonal sexual behavior (developmentally problematic) - children who engage in problematic interpersonal sexual behavior
including extensive adult-type sexual acts, are sexually preoccupied and display
problematic levels of masturbation, and the abuse is uncomfortable, sadistic and arousing,
and 5) Type 5-- Planned, coercive interpersonal sexual behavior (developmentally
problematic) - children who exhibit extensive, adult-type interpersonal sexual behavior,
high levels of problematic masturbation, sexual preoccupation and sexualized gestures,
and their abuse involves discomfort, self-stimulation and arousal (Kordich Hall et al.,
2002).

2.7 Current Treatment Methods and Models for Treating Trauma in Children

Since traumatized children are a unique population of clients, there are general
guidelines for working with them. The guidelines for working with children with trauma
in general, and sexual abuse specifically, are presented in this study to connect and
integrate specific methods and models of treatment.

2.7.1 Guidelines for Therapy with Children who were Victims of Trauma

Before describing specific treatment methods and models for treating trauma in
children, it is relevant to address some general, theoretically neutral guidelines that are
important for therapy with child victims of trauma, particularly sexual abuse. Many
researchers and clinicians agree that the effects of sexual abuse on children are diverse
with no specific syndrome. (Finkelhor & Berliner, as cited in Hetzel-Riggin et al., 2007;
Cohen, Berliner & Mannarino, 2000; Gordon & Schroeder, 1995; Putnam, 2003; Saywitz
et al., 2000). Due to this diversity, treatment of sexually abused children and their
families is difficult and there is no single intervention that is successful at treating this
population. Cook et al. (2005) confirmed that depending on the child and family,
multimodal treatment and several levels of care may be needed. Numerous researchers
and clinicians in different fields state that creating a sense of safety both in the therapeutic relationship and in the therapy environment is essential for treating victims of trauma in general and sexual abuse specifically (Crenshaw & Hardy, 2007; Dripchak, 2007; Henry, 1997; Kornblum, 2008).

Saywitz et al. (2000) reviewed available research on the effects of sexual abuse, the need for treatment, and the level of effectiveness of different treatment methods. Saywitz et al. (2000) along with Cook et al. (2005) and Gordon and Schroeder (1995) concluded that it was essential to include caretakers whenever possible in the therapy process for sexually abused children. Inclusion of caregivers allowed them to continue the management of the child’s symptoms outside of therapy using the following techniques: 1) use therapeutic techniques, 2) monitor the child’s symptoms over time, 3) help to prevent re-victimization, and 4) work to make improvements in the family environment. The caregiver’s involvement in the treatment process also helped them work on their own feelings of distress and other issues surrounding the child’s abuse, which ultimately could help the child (Saywitz et al., 2000).

Additional guidelines for planning interventions included those of Feiring and Cleland (2007) who studied the patterns of change in attributions in sexually abused children over a 6 year period. Attributions are a person’s cognitive attempt to make sense of why negative experiences, such as abuse (abuse-specific attributions), occurred and to place blame on someone for these experiences. Through this research Feiring and Cleland found that attributions were complicated and that blame was not a unipolar dimension. They warned that a therapist must remember that encouraging a child to blame the perpetrator may trigger the possibility that the child will blame themselves.
Deblinger and Heflin (as cited in Celano, Hazzard, Campbell & Lang, 2002) found that helping abused children learn about and reflect on abuse-specific attributions, initiated their own reevaluation of assumptions about their victimization, and created healthier views of themselves and others.

Perry (2006), along with his colleagues, created a process of assessment, staffing, and intervention called Neurosequential Model of Therapeutics (NMT) based on neurodevelopmental information. The NMT was used in various organizations and programs with as many as 2,500 children from infancy to young adult, all of whom were traumatized or maltreated in some way. The interventions used in NMT were based on the belief that each child was unique and had his or her own unique set of strengths and vulnerabilities. Perry’s treatment guidelines were: 1) Make sure that the experiences are relevant, relational, repetitive, and rewarding. Activities should be matched with the child’s developmental level of functioning, 2) Start therapy with easy, rhythmic, and repetitive activities that help regulate the brainstem functioning and organization, 3) If emotional material is present, the client’s state of mind will shift. If the shift is severe enough, he or she can become too anxious and unable to process this material, 4) The number of repetitions needed to help a child learn or develop certain capacities is often very high, 5) When a child feels safe, his or her arousal level can be kept at a manageable level and he or she can begin to benefit from traditional therapy methods, 6) The benefits of early intervention include increased effectiveness, services that will cost less, and progress that will be more dramatic, 7) It is easier to change beliefs than feelings, therefore, it is usually not that a child won’t change, it’s that change won’t happen unless enough repetitions occur, 8) One therapy session a week will not meet the needed amount
of interactions. Therapists need to network with other caring adults in the child’s life who could also provide therapeutic experiences.

Crenshaw and Hardy (2007) provided guidelines for treatment that specified the importance of using empathy in therapy for traumatized children to help them begin to talk about their traumatic experiences. Although the authors talked specifically about using their techniques in play therapy, many of their guidelines were applied to other treatment methods. The first important aspect of therapy was forming a trusting relationship with a traumatized child. It required empathetic attunement that was difficult to achieve because instead of genuine caring relationships, these children had frequently experienced betrayal, punishment, and being controlled. Developing a trusting relationship was essential to help the child feel more comfortable risking being close to others. It was through empathetic responses by the therapist that the child learned, in turn, to feel empathy towards themselves and others. A second important guideline was giving traumatized children an opportunity to tell their story, either verbally or symbolically through play, and know that their story was understood and witnessed by a person they trusted. This experience allowed children to create a new story and develop a new meaning and perspective on life. If these children found they were accepted, after sharing secret and shameful details about their traumatic experiences, they learned to accept themselves. Crenshaw and Hardy (2007) explained it was essential that therapy was guided by the child’s needs rather than either the therapist’s own interpretations of that child’s needs or the use of methods they thought represented effective therapy. Once a child reached the point of being able to express his or her traumatic experiences in some way, therapists were careful not to distance themselves or discourage the child. This
behavior would be detrimental to children and would leave them to work through these experiences and issues alone.

The results of research to compare various treatment methods indicated that therapy in a group format was successful with children who were sexually abused (Berlin & Ernst, as cited in Wolf, 1993; Silovsky & Hembree-Kigin, 1994; Wanlass, Moreno & Thomson, 2006; Wolf, 1993; Zamanian & Adams, 1997). Amand, Bard, and Silvosky (2008) conducted a meta-analysis of 11 outcome studies following treatment for sexual behavior problems (SBP). They evaluated 18 treatment methods of SBP and focused on finding relationships between child characteristics, treatment characteristics, and short-term outcome. Experts that worked with children with SBP believed that group treatment was particularly effective with this population (Araji, as cited in Amand et al., 2008). Amand et al. concluded that group treatment was the most common approach in SBP-focused treatment. Although the advantages of group treatment, as compared to other methods, was not empirically tested, multiple therapists that conducted group therapy with this population reported benefits to clients that were: 1) a reduced sense of social isolation and sense of being “different”, 2) a chance to learn different patterns of interaction with other children and adults, 3) more affordable, cost-effective treatment, 4) promotion of positive peer pressure and opportunity to observe models from peers in the group, 5) positive interactions and getting feedback from peers, and 6) easier assessment of the client’s social perceptions and skills (Silovsky, as cited in Amand et al., 2008).

In addition to treatment guidelines, the literature review for this study provided information on cautions, concerns, and challenges faced by researchers and clinicians working with traumatized children. Edwards and McFerran (2004) emphasized
challenges and difficulties when working with sexually abused clients and outlined recommendations for students in music therapy to use when working with this population. They stressed that work with children who were sexually abused was particularly difficult because: 1) despite treatment, some children do not improve or may become worse, 2) the optimal duration of treatment is unclear, 2) drop-outs are a significant problem, 3) there is question if asymptomatic children should be treated, 4) some clinicians believe boys are harder to treat than girls, and 5) intra-familial sexual abuse happens in an environment with personal, familial, and community problems that need to be addressed as well (Nurcombe, Wooding, Marrington, Bickman, & Roberts, as cited in Edwards & McFerran, 2004). Great diversity in the psychopathology of these children makes it unlikely that one form of treatment will meet the needs of all clients.

Related work by Henry (1997) determined if societal system interventions used to help sexually abused children could cause further traumatization. Henry (1997) examined trauma scores of 90 sexually abused children ages 9-19, from three countries, that were treated with interventions based on different societal systems, to determine the aspects of the interventions that were the best predictors of trauma scores. The trauma score for each child was determined using the Trauma Symptom Checklist for Children (Briere, as cited in Henry, 1997) that measures six subscales that are characteristic of traumas in sexually abused children. The results indicated that the statistically significant predictors of trauma scores were the number of interviews conducted with the children, and whether the child had a trusting relationship with a treatment provider. Overall, most children believed that the system interventions were beneficial. Henry warned that children that were forced to repeatedly tell about their abuse experiences could connect
with painful memories that would potentially reinforce the internalization of guilt and shame created by the sexual abuse. The trusting relationships that children developed with professionals could be harmed when they were asked the same questions many times. Although abused children were repeatedly betrayed by adults, most of them were still willing to develop a relationship with a caring adult. These caring relationships helped counteract previous betrayals and gave these children a chance to feel safe and secure; an important part of psychological and emotional recovery that could also reduce the possibility of further trauma. When analyzing the different types of societal system interventions, Henry found the ability of professionals to develop positive caring relationships with these children was essential to any system intervention. Interventions by professionals needed to respect the integrity of the children. Henry warned that professionals must not make promises to abused children that were not guaranteed because it damaged the child’s level of trust in them. Finally, when children were encouraged to disclose information about their abuse it was crucial that the professional provided open and honest information for the child about what might happen once he or she disclosed. The adult had to be prepared to answer the child’s questions in terms of placement, perpetrator incarceration, and possible familial responses. If these precautions were not taken the child could easily feel betrayed when these situations occurred.

Cohen, Deblinger, Mannarino & de Arellano (2001) researched the importance of culture on: 1) the development of symptoms, 2) treatment-seeking behaviors, 3) treatment preference, and 4) reactions following child maltreatment on both children and their families. They stated it was important that therapists treating this population developed
cultural sensitivity because treatment of abuse and neglect touched on issues influenced by ethnic and religious beliefs that included: 1) different views on sexuality, nudity, discipline practices, and parent/child relationships, 2) cultural norms and expectations concerning children’s behavior within the family and the community at large, 3) varying ways that adults and children interact, and 4) different emotional and behavioral parental reactions to sexual abuse disclosure that significantly affects a child’s recovery. Emotional and behavioral symptoms, attitudes towards child abuse, and child-rearing practices were greatly affected by culture and had a significant influence on therapeutic work. Therapists needed to be aware of these factors and able to discuss them as part of the treatment process.

2.7.2 Specific Treatment Methods and Models for Traumatized Children

Many schools of therapy created techniques, guidelines, methods, and models to treat traumatized children. In some forms of therapy models were developed specifically for work with this population. Other therapy methods required adaptations to increase their success in treating traumatized children. The methods and models reviewed in this section were studied and published most frequently and were used in therapy with children who had general or sexual abuse traumas.

2.7.3 Psychodynamic/Psychoanalytic Based Therapy

2.7.3.1 Definition of Psychodynamic/Psychoanalytic Based Therapy

Psychoanalytic therapy analyzes psychodynamic factors that motivate behavior, particularly the unconscious. To address issues, psychoanalytic therapists bring the client’s unconscious thoughts into his or her conscious thoughts. Psychoanalytic therapists stress strengthening a client’s ego so that “behavior is based more on reality
and less on instinctual cravings or irrational guilt” (Corey, 2005, p.65). They reconstruct, discuss, interrupt, and analyze a client’s childhood experiences to increase the self-understanding that will aid in the process of change (Corey, 2005). Four basic concepts of psychoanalytically oriented psychotherapy are: 1) the existence of unconscious mental processes, 2) the belief of internalized conflicts leading to symptoms or defenses, 3) the significance of these symptoms, and 4) transference as a way to understand client-therapist interactions as reenactments of past experiences (Shapiro & Esman, as cited in McElroy & McElroy, 1989). Anna Freud and others altered psychoanalytic techniques to specifically work with children (McElroy & McElroy, 1989).

Control-mastery theory is a specific psychoanalytic theory that is often used to develop and carry out treatment for traumatized children. This theory states that children are intrinsically motivated to work towards developmental goals, while at the same time they try to keep a good relationship with their parents because they depend on them to survive. When children sense that their efforts to achieve developmental goals upset their parents or negatively affect their relationship with them, they give up the goals to meet the inferred needs of their parents. This process occurs many times during childhood development and shapes the child’s personality and behavior, but doesn’t necessarily cause psychopathology. Psychopathological issues are often created when “a parent consistently reacts to the child’s pursuit of developmental goals in a way which is a source of trauma for the child” (Suffridge, 1991, p.69). If children are met with rage, anxiety, rejection, or withdrawal from their parents while pursuing their developmental goals, they might develop pathogenic beliefs that trying to reach their goals is somehow dangerous or possibly harmful to their parents. They will stop trying to reach those goals.
These beliefs and inhibition of behaviors usually functions at the unconscious level and lead to psychological symptoms and disorders. It is believed that when clients enter psychotherapy they unconsciously try to disconfirm their pathogenic beliefs. It is the therapist’s job to help them to develop insight into these beliefs to guide mastery of developmental goals that were put on hold (Suffridge, 1991).

2.7.3.2 Psychodynamic/Psychoanalytic Based Therapy Methods/Techniques with Traumatized Children

Overall there was a limited amount of literature available that concerned psychodynamic/psychoanalytic therapy methods and techniques with traumatized children. Most of the literature, either foundational or recent, focused on adults or entailed very specific clinical descriptions rather than general methods, techniques, or work with a specific population. Therefore, to give an overview of this area of therapeutic work and literature, some older literature and more recent literature with adults was included.

McElroy and McElroy (1989) summarized psychoanalytic based interventions for sexually abused children. Therapists using psychoanalytic techniques tried to reduce the trauma that was interfering with a child’s normal development and redirect the child back to a normal pattern of psychological growth (Nagera, as cited in McElroy & McElroy 1989). Therapists often engaged the child in play activities to observe various aspects of them. Psychoanalytic oriented therapists worked to develop trusting, therapeutic relationships by allowing the child to bring up information when he or she was ready and then using techniques of psychodynamics to help them. Psychoanalytic psychotherapy for sexually abused children focused on: 1) present issues, 2) recent memories of the
abuse, and 3) past memories (Sandler, Kennedy, & Tyson, as cited in McElroy & McElroy, 1989). In psychotherapy, therapists tried to make unconscious material conscious and help the child understand the reasons for his or her symptoms and behaviors. Therapists looked for the use or overuse of any defenses that the sexually abused child was using to cope; this gave the therapist information about the child’s level of anxiety and the controlling nature of the child’s affect.

Psychoanalytic interventions addressed the client’s anxiety, symptoms, and defenses through clarification, confrontation, and interpretation. These interventions helped children accept thoughts and memories hidden in their unconscious prior to therapy (Sandler, Kennedy, & Tyson, as cited in McElroy & McElroy, 1989). By restating the child’s feelings, using clearer and more precise language, the therapist improved the child’s self-understanding (Bibring, as cited in McElroy & McElroy, 1989). To avoid resistance, the therapist never clarified information that the child didn’t already know. Clarification helped the child differentiate between fantasy and reality, provided reassurance and correct information, and worked to prevent self-blame. Confrontation was used when a child denied information that was confirmed as fact. The therapist was firm but gentle and acknowledged that the child was denying the truth (Sandler et al., as cited in McElroy & McElroy, 1989). Confrontation also was used to provide educational information such as sex education or corrections to misconceptions about the negative physical effects of abuse (Damon, Todd, & MacFarlane, 1987; Sgroi, 1982). Interpretation was the main intervention in this form of psychotherapy. It was a long process achieved by the therapist making verbal statements to help the child realize his or her defenses or resistances, and help them directly experience painful feelings and
memories (Coppolillo, as cited in McElroy & McElroy, 1989). This intervention illustrated for the child the connection between defenses and what was being defended against (A. Freud, as cited in McElroy & McElroy, 1989).

Suffridge (1991) described using control-mastery theory, a specific psychoanalytical theory, to treat childhood maltreatment and determine the effects of maltreatment by examining pathogenic beliefs that were developed during childhood. Due to their strong need to keep positive relationships with their parents, abused children might believe that they deserved the abuse. These beliefs create other negative beliefs about their self-worth and entitlement. By providing children space to work through their pathogenic beliefs, the children often repeated the same negative interactions they had with their parents with the therapist to see how they reacted. This behavior allowed the therapist to develop insight into the child’s issues and help them remember previously unconscious or undisclosed information (Suffridge, 1991).

An approach by Chertoff (1998) used ego psychological and psychodynamic approaches and addressed how psychodynamic assessment and treatment of traumatized clients was beneficial. Psychoanalysts that used an ego psychological orientation believed that trauma was an external event(s) that overwhelmed the client’s ego defenses causing them to loose previously mastered developmental skills (Sugarman, as cited in Chertoff, 1998). Therapists using psychodynamic techniques believed that they didn’t know if or how an event was traumatic until they could define both the meaning of the trauma and the client’s response to the trauma using the treatment process. They did not need these types of answers to begin therapy with a trauma client, which was not typical for some other treatment methods. Psychodynamic psychotherapy could help clarify both
the meaning and influence that traumatic experiences had on a client to better understand his or her symptoms. These therapists believed it was important when working with trauma clients to: 1) recognize the extent that certain events have led them to lose some of their ability to cope with internal and external stimuli, 2) determine their typical coping skills, and 3) understand developmental and hereditary elements that might contribute to their ego strengths and vulnerabilities.

Lovett (2007) described the case of a 5-year-old girl who was sexually abused and attempted to understand the experiences of this child by using the theories of psychodynamics and neurobiology. The author recommended an intervention that incorporated multiple modalities including play therapy, dyad treatment, parental involvement, and case management. It was stated that repeated opportunities for interacting and using socially acceptable ways of expressing feelings and needs, could actually help reconstruct, on a neurological level, the techniques a child used for coping with stress and anxiety. Lovett believed that it was important to include the non-offending parent(s) or caregiver(s) in the treatment process because they offered a holding environment to both stabilize the child and reduce her need to become hyperaroused. Since many sexually abused children had attachment issues, it was important to include non-offending parents or caregivers in therapy. Dyad treatment helped to develop a sense of security and acceptance. Lovett stated that case management was essential to working with sexually abused children because many people were involved in a child’s life and that everyone needed to work together to successfully help the child.
2.7.4 Cognitive Behavioral Therapy (CBT)

2.7.4.1 Definition of CBT

All forms of Cognitive Behavioral Therapy (CBT) have similar attributes: 1) a collaborative relationship between client and therapist, 2) the belief that psychological distress was mainly due to disturbances in cognitive processes, 3) a focus on changing cognitions and creating the desired changes in affect and behavior, and 4) generally a time-limited and educational based form of treatment that focuses on specific problems. Cognitive behavioral therapists believe that if a person’s self-statements are reorganized than his or her behavior will also be reorganized (Corey, 2005).

2.7.4.2 CBT Methods/Techniques with Traumatized Children

The directive and supportive aspect of CBT is important in treating a sexually abused child because less direct approaches might allow avoidance and continue the child’s silence relative to his or her abuse (Ross & O’Carroll, 2004). Ross & O’Carroll (2004) completed a literature review of CBT treatment studies for CSA and summarized the common techniques as: 1) gradual exposure, 2) modeling, 3) education, 4) coping, and 5) body safety skills training. Gradual exposure aimed to sever the child’s association between very negative feelings and abuse related thoughts. In theory, repeated exposure of the child to fearful thoughts and reminders of his or her abuse would eventually reduce the child’s level of anxiety and avoidance behavior. A reduction in anxiety freed the child to retrace the abusive experience cognitively and affectively under the continued guidance of his or her therapist and non-offending caregivers. Non-offending caregivers were included in the CBT process to provide them with education on the issues arising from sexual abuse of children and to teach them coping skills. The
non-offending caregivers could express their concerns, and experience modeling and gradual exposure similar to their children’s experience. Cognitive behavioral therapists were concerned with the cognitive factors of abused children such as: 1) their perceptions of the abuse, 2) the meaning they created from the abuse, and 3) their beliefs about themselves and the world around them (Ross & O’Carroll, 2004). The therapists determined whether these key beliefs were functional or dysfunctional because this information influences the symptoms children develop following abuse (Lipovsky, as cited in Ross & O’Carroll, 2004).

Cognitive behavioral therapy methods and techniques used specifically with traumatized children were described in an article by Faust and Katchen (2004) who outlined the characteristics of traumatic events and other variables that could place a child at risk for a complicated traumatic reaction. The interventions they suggested to address symptoms of children with a complicated trauma reaction were: 1) safety planning, 2) grief work, 3) family therapy, 4) cognitive behavioral individual treatment, and 5) using various structural systems for children such as schools. Of particular interest to this section on CBT, was the extensive description of how CBT could most effectively be used to help children with PTSD. In general, CBT for this population had four procedures: 1) coping skills instruction, 2) relaxation training, 3) systematic desensitization, both in imagination and quasi in vivo and 4) behavioral education for parents that focuses on making a contract to increase compliance and reduce their fear (Faust & Katchen, 2004). In the first procedure, children were taught coping skills to help reduce anxiety and break the connection between anxiety and reinforcing aspects of avoidance. Coping skills also improved the child’s sense of mastery and self-worth and
helped them gain control in using new skills to master fear and anxiety. Therapists used CBT with children who had PTSD to teach them adaptive self-statements for support during the desensitization process or any time they came into contact with fearful stimuli outside of therapy. Therapists also used CBT help their clients identify and challenge maladaptive self-statements, particularly those related to the trauma and resulting fear. The clients were asked to create adaptive cognitions and attributions (attempting to make sense of why certain experiences occurred) in addition to replacing maladaptive self-statements with adaptive ones. During the second procedure, children with PTSD were taught relaxation skills, using techniques such as diaphragmatic breathing and progressive body-muscle relaxation, which were developed especially for children. A modification made by therapists to the progressive body-muscle relaxation technique was to use imagery during the tense-relax phase of each muscle group. After this technique was completed, the therapist asked children to imagine a safe relaxing place to go their mind. Once the children had finished learning relaxation skills, they were encouraged to develop a hierarchy of their fearful stimuli. If a child was unable to come up with details of the traumatic event or fearful stimuli due to the avoidance aspect of PTSD, the caregivers could help fill in gaps and provide other information not available to the child such as that found in legal documents. The caregivers could, on their own, make a fear hierarchy for the child as well. The child, with the therapist’s help, rated each item in the fear hierarchy and the caregivers also rated each item. Once the hierarchy was rated, the therapist gradually exposed the child to his or her feared stimuli using the child’s imagination as the therapist describes the stimuli. Finally in the fourth procedure, caregivers were taught parenting skills that could improve their child’s coping, such as
rewarding the appropriate use of coping skills and adaptive self-statements, and helping
the child to eradicate maladaptive fear responses.

Cohen, Mannarino, and Rogal (2001) conducted a survey of different treatment
methods currently being used treat PTSD in children. The researchers sent anonymous
surveys to 207 child psychiatrists and 460 non-physician therapists asking about their
current treatment methods for children with PTSD. The results indicated that CBT was
the preferred method of treatment for non-medical therapists and the second most
preferred for child psychiatrists. Cohen et al. (2001) speculated that these findings were
correlated with the strong interest of clinicians to work with the PTSD population and
their desire to keep up to date with current research that supported the efficacy of using
CBT for this population. Also, researchers and clinicians in the field of CBT made a
great effort recently to publicize this method through national and international
presentations (Cohen & Mannarino 1998a; March, Amaya-Jackson, Murry & Schulte, as

Numerous studies tested the specific effectiveness of CBT with sexually abused
children. A study by Farrell, Haines and Davies (1998) examined the effectiveness of
CBT with four sexually abused children showing PTSD symptoms. They observed a
reduction in PTSD symptoms in all four participants. A reduction in depression and
anxiety was seen in three participants who already had demonstrated some improvements
in these two issues before the study began. In this study, the CBT included: 1)
educational aspects, 2) self-monitoring, 3) relaxation training, 4) cognitive restructuring,
5) role-playing, and 6) in vivo practice of skills. Deblinger et al. (2001) compared the
effectiveness of CBT for both children ages 2-8 who were sexually abused and their non-
offending mothers to other supportive therapy used for the same population. Activities were selected for both therapy methods that encouraged the children to: 1) communicate about and cope with their emotions, 2) identify “okay” and “not okay” forms of touching, and 3) learn abuse response skills. Due to the young age of the children in therapy, they were never asked to talk directly about their abusive experiences although some children did disclose information. Instead, therapists used an interactive format with worksheets, role playing, behavior rehearsal, and activities that included both parent and child. The results indicated that children in the CBT group showed greater improvements in their understanding of body safety skills after therapy. Post therapy tests revealed that non-offending mothers in the CBT group had a greater reduction in their intrusive thoughts and their negative emotional reaction to their child’s abuse (Deblinger et al., 2001). In an earlier study by Deblinger and Heflin (as cited in Deblinger et al., 2001), sexually abused children and their non-offending parents were either given CBT intervention or placed in a control group that didn’t receive any treatment. The children who were involved in CBT had a greater reduction in their externalizing behaviors, post traumatic stress disorder (PTSD), and level of depression. A more specific description of modeling, skills training, gradual exposure, education, and prevention training were presented in Deblinger et al., 1990.

Another CBT research study by King et al. (2000) evaluated the efficacy of participation by sexually abused children with posttraumatic stress symptoms and their caregivers. The study participants were 36 sexually abused children randomly assigned to one of three groups for 21 sessions: 1) child-alone cognitive behavioral treatment, 2) family cognitive behavioral treatment, or 3) waiting list control. The results indicated
that children involved in either of the two treatment conditions had significant
improvements in their posttraumatic stress symptoms and in reports of fear and anxiety.
The improvements were still present at a 12 week follow-up test. Overall, parental
involvement did not improve the treatment outcome. The treatment for the children in
the child-alone cognitive behavioral group generally consisted of: 1) an initial assessment
of the child’s issues, 2) explanation of the rationale for the program, 3) goal setting, and
4) information concerning child sexual abuse and an explanation of PTSD based on the
theories of CBT. The remaining 20 sessions were focused cognitive therapy, behavioral
rehearsal, relaxation skills, and skills to cope with troubling memories of abuse and
feelings of guilt and anxiety. In addition, the children were taught to recognize and think
about self-talk when in anxiety producing situations. They also learned how to use more
positive self-talk that was emphasized through visual, picture materials. Therapists
taught the children to use more assertive behaviors through exposure exercises that
included: 1) imagination, 2) drawings, 3) role-playing, 4) writing stories, and 5)
discussion. If a child felt anxious or scared during an exposure activity, the therapist
would remind the child to use previously learned coping skills to keep feelings under
control. The last treatment sessions were focused on: 1) relapse prevention, 2) education
on issues such as body ownership, 3) touching, 4) the right to say no, and 5) learning
safety skills to use in response to future inappropriate sexual advances or touching. The
participants in the family cognitive behavioral treatment received the same treatment. In
addition the non-offending parents participated in 20 training sessions in child behavior
management skills and parent-child communication skills (King et al., 2000).
2.7.5 Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)

2.7.5.1 Definition of TF-CBT

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) is an empirically supported therapy model designed to help children, adolescents, and their parents deal with the effects of trauma (Cohen, Mannarino & Deblinger, 2006). This form of therapy combines: 1) trauma-sensitive interventions, 2) cognitive behavioral principles, 3) theories of attachment, 4) developmental neurobiology, and 5) family, empowerment, and humanistic theoretical models. The focus of TF-CBT is to address symptoms of PTSD, depression, and anxiety and associated issues. The core values of TF-CBT are defined in the acronym CRAFTS: Components based, Respectful of cultural values, Adaptable and flexible, Family focused, Therapeutic relationship are central, and Self-efficacy is emphasized. Individual therapy is provided for children and parents separately and in conjoint sessions, however, TF-CBT is primarily child focused and can be provided for children without inclusion of their family. Therapists using TF-CBT stress open communication within families but are cognizant of the need for consent from older children and adolescents before sharing information with their parents. The components of TF-CBT form the acronym PRACTICE: Psycho-education and parenting skills, Relaxation, Affective modulation, Cognitive coping and processing, Trauma narrative, *in vivo* mastery of trauma reminders, Conjoint child-parent sessions, and Enhancing future safety and development. Usually therapists address the components of TF-CBT in the above order, however, they might blend components together or go back and revisit components previously presented that need to be reviewed. Cohen, Mannarino, and Deblinger (2006) emphasize that since TF-CBT teaches specific strengths and skills to
clients, children and their families are encouraged to practice the components of TF-CBT outside of therapy. There are two specific treatment models that are based in the theories and methods of CBT and focus on a particular population. These models include Sexual Abuse-Specific Cognitive Behavioral Therapy (SAS-CBT) (Cohen and Mannarino, 1998a), and Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP) (Cohen & Mannarino, 1998b).

2.7.5.2 TF-CBT Methods/Techniques with Traumatized Children

Cohen (2003) completed research on using TF-CBT for the treatment of PTSD and related emotional and behavioral issues in children who were sexually abused. Cohen presented the importance and feasibility of early screening of trauma exposed children. Cohen explained that research was needed to: 1) determine the success of specific components of TF-CBT interventions in treating the effects of trauma, particularly PTSD, and 2) determine optimal timing and duration of TF-CBT for acutely traumatized children. Therapists were warned of the potential for increased risk during early intervention treatment that reminded children of their traumatic experiences without providing the chance to resolve their trauma related symptoms.

Cohen, Deblinger, Mannarino, and Steer (2004) compared the effects of TF-CBT and child-centered therapy on the treatment of PTSD and related emotional and behavioral issues in children who were sexually abused. Techniques were selected for use in TF-CBT to address the components of PRACTICE as previously described. As sessions progressed, children were encouraged to deal specifically with more detailed and distressing reminders and memories of the trauma or abuse. Children were asked to create narratives of their traumatic experience either by writing or drawing in a journal
that, with their consent, was shared with their parents in joint sessions. Specific goals during TF-CBT included: 1) building skills for expressing emotions, 2) learning and practicing coping skills, 3) becoming aware of the relationships between thoughts, feelings, and behaviors, 4) participating in the process of gradual exposure, often through the creation of a trauma narrative, 5) cognitive processing of traumatic experience(s), 6) joint parent-child sessions, 7) psycho-education about sexual abuse and body safety, and 8) parent management skills (Cohen et al., 2004).

Another randomized controlled trial study by Cohen, Mannarino, and Knudsen (2005) compared the length of treatment effects for two brief 12 week treatment approaches using either TF-CBT or Non-directive Supportive Therapy (NST). The results of this study demonstrated that TF-CBT was more effective than NST in treating depression, anxiety, and sexual concern symptoms in children over the course of a year. In addition, children in the TF-CBT group showed significantly greater improvements in PTSD and disassociative symptoms after one year than those in the NST group. These results were consistent with other studies that measured the effectiveness of TF-CBT and they added support to the evidence for TF-CBT being effective and durable in the treatment of sexually abused children.

Another related therapy method that is designed to target issues specific to trauma is Sexual Abuse Specific-CBT (SAS-CBT). Cohen and Mannarino (1998a) conducted a study to evaluate treatment outcome for sexually abused children who were randomly assigned to either receive SAS-CBT or NST. They explained that SAS-CBT was created to address the presenting issues of sexually abused children. Usually SAS-CBT focused primarily on: 1) depression (feeling helpless/powerless, distorted attributions, feeling
damaged/different, lower self-esteem), 2) anxiety (reducing anxiety, enhancing safety, managing intrusive thoughts), and 3) behavioral difficulties related to depression and anxiety (learning connections between thoughts, feelings, and behaviors, learning about age-appropriate behavior, interventions for inappropriate behavior, and problem solving skills). This form of therapy, like TF-CBT, included parents of sexually abused children because they saw that the parent’s emotional reaction to the sexual abuse had a strong effect on the child’s symptoms. Good maternal support was positively correlated with a positive child outcome from therapy (Hewitt, as cited in Cohen & Mannarino, 1998a).

The goals for SAS-CBT with parents included: 1) decrease emotional distress, 2) enhance support of their child, and 3) manage the behavioral difficulties of their child that were related to abuse. Specific interventions used during SAS-CBT sessions included: 1) building relationship-social skills, 2) monitoring and modifying automatic thoughts, assumptions, and beliefs (cognitive reframing), 4) teaching problem-solving skills, 5) contingency reinforcement, and 6) modeling that includes role-playing, social reinforcement, and positive feedback. Various research studies provided support for using SAS-CBT with children who were victims of trauma and sexual abuse specifically (Cohen & Mannarino, 1998a).

Cohen and Mannarino (1998b) conducted another study as a follow up to their 1993 study to examine the impact of development, demographic, and familial factors and the type of treatment on the outcome 6 and 12 months after treatment for sexually abused children in their 1993 study. The original study compared two treatment methods, one created by the researchers called Cognitive-behavioral therapy for sexually abused preschoolers (CBT-SAP) and NST. The results overall emphasized the impact parental
support and emotional reaction to abuse had on the functioning of sexually abused children’s over time. Therefore, the researchers stressed how important it was to include parents in the treatment process of these children. Comparison between the two methods of treatment and the duration of their effects revealed that cognitive-behavioral treatment along with services to improve parental support were most effective over time.

2.7.6 Eye Movement Desensitization and Reprocessing (EMDR)

2.7.6.1 Definition of EMDR

Eye Movement Desensitization and Reprocessing (EMDR) is a form of psychotherapy that is client-paced, and based on psychodynamic treatments. It was originally created by Shapiro (1995) to help treat traumatic memories in adults with PTSD, and continues to be used often to reduce the symptoms of PTSD (Severe, 1997). This form of therapy incorporates both the biological and the psychological roots of people’s issues (Solomon & Heide, 2005). There are eight phases to EMDR based on an information processing model that assumes pathology is based on perceptual information that an individual has stored in a maladaptive way (Shapiro, 2001). Therapists use EMDR to: 1) emphasize perceptual aspects of experiences (affective, cognitive, and somatic), 2) speed up the client’s access and processing of traumatic experiences, and 3) strengthen a client’s internal resources so that he or she can make behavioral and interpersonal changes (Shapiro, 2002).

In EMDR, it is essential for the client to actively participate in several steps of the treatment. Clients are asked to identify a distressing memory and any related imagery and sensations, and rate it on a 10-point Subjective Units of Distress (SUD) scale (Shapiro, 1995). Next the client is asked to identify both negative and positive trauma-
related cognitions. The negative cognitions are rated on a 7-point scale called the Validity of Cognition Scale (VOC). After these steps are completed, the client is instructed to track the therapist’s hand as it moves back and forth while at the same time, they focus on the memories, related images, thoughts, and sensations. The therapist monitors the number of eye movements to maintain them at ≥ 24. Instead of moving their hand the therapist can use hand taps or sounds. This is important when working with young children that do not have fully developed eye coordination. Therapists can tap the child’s left and right hand in a left-right pattern. In between sets of eye movements, the therapist has the client verbalize his or her thoughts, images, feelings, and sensations. Later in the therapy process, therapists use a technique called “reprocessing” where clients focus on positive cognitions in terms of the memory while more sets of eye movements are done (Chemtob, Nakashima & Carlson, 2002).

The mechanisms that make EMDR successful continue to be investigated and there are varied opinions held by therapists and researchers as to how EMDR helps clients. Shapiro (2001) suggests that EMDR induces accelerated information processing that helps the individual access and integrate disturbing information and make it less damaging. Others believe that acceleration in information processing is related to REM dreaming (Greenwald, 1998). The cognitive element of EMDR is asking clients to create a positive cognition to replace negative beliefs. The client is taught techniques to contain anxiety or intense emotions by going to a safe imagined place (Solomon & Heide, 2005).

2.7.6.2 EMDR Methods/Techniques with Traumatized Children

Greenwald (1998) presented information from literature reviews of EMDR, results of research on the effects of using EMDR with children and adolescents, and case
material on procedures used in EMDR. Greenwald explained that EMDR could significantly improve the treatment of psychological issues related to traumatic memories, particularly PTSD symptoms. Studies on using EMDR with traumatized children and adolescents indicated that EMDR treatment might work more quickly with children but was equally successful with traumatized children and adults. The review of literature indicated a need for training to master age-appropriate technical variations of EMDR techniques. Greenwald explained that more research was needed to confirm the success of EMDR in the treatment of traumatized children.

Greenwald (1994) presented five case studies that examined the successful use of EMDR with five 4 to 11-year-old Caucasian and Hispanic children who developed PTSD symptoms after witnessing Hurricane Andrew. Not only were PTSD symptoms significantly reduced at both the one and four week post-treatment sessions, the children also returned to pre-trauma levels of functioning. Parents reported several changes in their children post EMDR including: 1) increase in happiness, 2) better concentration and performance at school, 3) more cooperative and responsible behavior, 4) less emotional reactivity, and 5) better sibling relationships. Greenwald explained that results of EMDR will differ by the: 1) way the treatment is applied, 2) techniques therapists use, 3) level of resistance by the client when recalling painful memories, and 4) focus and pace set for the session that should match the tolerance level of the client.

Severe’s (1997) doctoral research examined using EMDR treatment for a latency aged child with PTSD. Severe described the EMDR treatment methods used for this child that were very similar to those described previously in this section. As part of this
research, Severe discussed the foundational work of Greenwald (1993), Pellicer (1993) and Tinker (1995) that used EMDR with children.

Maxfield and Hyer (2002) reviewed controlled treatment outcome studies to test the effectiveness of EMDR in treating PTSD. They compared the outcomes of the studies to determine if variation in the results was due to methodological differences. Overall, the studies with better methodology indicated that EMDR was an effective treatment for PTSD. One of the strong benefits of using EMDR with traumatized clients was that often only a few sessions were needed to relieve some of the posttraumatic symptoms. Chemtob et al. (2002) studied the effectiveness of using EMDR as a brief intervention for elementary school children with disaster-related PTSD. The structure of the intervention for this group of children consisted of one initial diagnostic session and three weekly treatment sessions. The treatment was comprised of four stages: 1) introduction and assessment, 2) worst memory, 3) current reminders, and 4) future events. The therapist used the diagnostic sessions to build rapport, explain the treatment, measure presence or absence of PTSD, and create a “safe place” with the child’s help using EMDR-like techniques. In the first treatment session, the therapist conducted two sets of eye movement procedures to install a safe place in the child’s mind. Next, the most distressing memory of the disaster was recalled during typical EMDR procedures. The first session was ended by having the child concentrate on a positive cognition. In the second session, the most distressing reminders of the disaster were processed, and the final session focused on the child’s fears about future disasters. If other upsetting memories came up during the sessions the therapist addressed these using the EMDR techniques as well. To end the treatment process, feelings concerning termination were
discussed and gains from therapy were reviewed. The intervention resulted in significant improvements in PTSD symptoms that were sustained at a 6 month follow-up.

Tufnell (2005) described her clinical work using EMDR to treat PTSD in four pre-adolescent children. Tufnell believed that EMDR was successful with children if adjustments were made to the techniques and procedures based on the child’s developmental level. Often young children were unable to understand standard EMDR procedures so different methods were needed to help them recall the traumatic experiences and reprocess this information. Tufnell explained that additional methods might need to be added to the treatment plan when using EMDR with children who have other complex issues beyond PTSD. In general, EMDR was most effective for treating a single, simple, acute trauma event. The effectiveness was reduced slightly as the traumatic symptoms become more chronic. Also EMDR did not produce quick, effective results when used to treat multiple and complex traumas such as abuse. Tufnell referenced the work of Tinker & Wilson (as cited in Tufnell, 2005) who explained that EMDR could help reduce some symptoms if a traumatic situation was continuing, but for full recovery the trauma must stop completely (Tufnell, 2005).

Ahmad and Sundelin-Wahlsten (2008) were interested in finding ways to alter the methods of traditional EMDR to make them effective for children with PTSD. The objective of their study was to find a child-adjusted protocol for EMDR by making alterations and applying them to 33 children with PTSD ranging from 6 to 16 years of age. Their results indicated that the child-adjusted protocol was applicable, after modifications were made to adjust for age and developmental level, because the ability to identify positive and negative cognitions and emotions was based on these levels. Using EMDR
allowed the therapist to help children explore and identify their thoughts and feelings in specific situations and recognize positive versus negative cognitions. Clearly EMDR had connections to cognitive psychotherapy, so similar techniques with children could be used to alter EMDR.

Koch (2006) described the body therapy aspects that made EMDR particularly applicable for work with traumatized individuals. An important idea in EMDR was that the brain is part of the body. Therefore the body is an effective place to apply processes of change. In EMDR, therapists used rhythmic movement to create structure. It was physiologically stimulating but cognitive-emotionally relaxing. The horizontal plane, also called the “table” plane (the space from side to side and front to back), is the movement plane used in the first year of life. It followed that using the horizontal plane for eye movements was significant as it was connected to the observation, communication, attention, and orientation associated with the horizontal plane. Horizontal movement (movement in the horizontal plane) was best to use when trying to connect to the most primitive areas of the brain affected by trauma. The techniques of EMDR provided an anchor to the here and now and allowed the client to both be in control and decide the tempo of what he or she did, which could also reduce arousal.

2.7.7 Group Therapy

2.7.7.1 Definition of Group Therapy

Group therapy is structured on the qualities of the group members, the purpose of the group, and the background and technique of the group leader(s). Diverse approaches used in group therapy include: 1) cognitive behavioral, 2) psycho-educational, 3) interpersonal, 4) gestalt, 5) supportive-expressive, 6) psychoanalytic, 7) dynamic-
interactional, and 8) psychodrama. Therapy groups are available for people with a range of mental health issues from panic disorders, depression, and eating disorders, to physical conditions such as cancer, HIV/AIDS, and Parkinson’s disease. Group therapy is provided in a variety of clinical settings including medical and psychiatric hospitals, battered women’s shelters, prisons, and private psychotherapy offices (Yalom, 2005).

According to Yalom (2005) the 11 therapeutic factors that create change in group therapy are: 1) instillation of hope, 2) universality, 3) imparting information, 4) altruism, 5) corrective recapitulation of the primary family group, 6) development of socialization techniques, 7) imitative behavior, 8) interpersonal learning, 9) group cohesiveness, 10) catharsis, and 11) existential factors. It is important that all of these factors are explored in group therapy to make the treatment most effective.

2.7.7.2 Group Therapy Methods/Techniques with Traumatized Children

Historically, group therapy dealt directly with children’s feelings of isolation and social stigmatization. It was considered very effective for treating traumatized children, particularly those who were sexually abused (Celano, as cited in Silovsky & Hembree-Kigin, 1994). Group therapy addressed feelings of shame that victimized and traumatized children often experienced by giving them a chance to be in a group, tell their story with peers, and learn that other children had similar experiences (Weille, as cited in Carbonell & Parteleno-Barehmi, 1999). Positive and constructive group experiences could create change in the children’s sense of isolation and worthlessness (Carbonell & Parteleno-Barehmi, 1999). Group therapy provided an environment where children who were traumatized could connect and have their symptoms normalized by learning that others experience the same issues. As the children in a group began to feel
more connected to one another, they experienced the extension in their social network that was essential for trauma recovery. The group as an entity grew to be reparative, supportive, and provided a safe place for the members (Haen, 2005).

Zamanian and Adams (1997) expanded our knowledge of the unique dynamics and challenges of group treatment with sexually abused children, particularly boys by describing themes, issues, and interventions of one therapy group with sexually abused boys. They explained that some therapy groups created structure by having both overall goals and activities and also specific goals for each meeting. The goals were stated and explained at the beginning of the sessions. Some therapy groups began by giving children time to talk about any concerns, thoughts, and/or feelings related to being in the group. If issues related to trauma weren’t introduced by group members, the therapist might directly introduce the topic through discussions. Open discussions about sexual abuse, in particular, were important due to the different levels of understanding for children. Their ability to understand the abuse and their definitions of sexual abuse were often too narrow and they minimized their traumatic experiences. Zamanian and Adams (1997) described inevitable conflicts between members, especially if the group only had boys in it. The therapists must be flexible and creative to appropriately use conflicts as learning opportunities for the group. A group environment that encouraged self-disclosure by many people, and positive peer support, often decreased the member’s resistance to therapy. Interventions that built this type of environment included developing group boundaries and learning to contain uncontrolled affect.

A specific example of group therapy with abused children was included in a study by Wanlass et al. (2006) that was conducted with girls, ages 10-14, who were victims of
incest. The four main objectives for the group were to: 1) provide emotional support for members who were going through a difficult time, 2) provide a place for members to work through their victimization, 3) provide a place to discuss normal developmental concerns, and 4) build skills associated with resiliency such as improving self-esteem, developing interpersonal supports, and fostering adaptive coping strategies. Therapists selected psychotherapy to address effects of the abusive trauma and also used techniques of psycho-education and group counseling. By addressing all levels of traumatic experience in therapy, they hoped to repair the negative effects of abuse and facilitate normal development. Wanlass et al. warned that the upsetting and overwhelming nature of issues present in abused children required group leaders to provide containment and support for members as they worked through these issues. Containment could be provided through establishing boundaries and providing specific structured activities.

Heiman and Ettin (2001) described short-term, structured group therapy for school aged girls who were sexually abused. The selected group attended 11 structured, one hour sessions. Additional sessions were offered for their parent’s part way through the treatment. The authors focused on the dynamics and processes involved in the group structure. They emphasized listening to the hidden message of children’s actions and being able to respond to these messages rather than stop the behavior. The central goals for these types of groups usually were to: 1) share, ventilate, and validate feelings related to abuse, 2) develop assertiveness and protective skills, 3) develop age appropriate behaviors, improve social skills, and reduce sexualized behaviors, 4) improve impaired self and body image, 5) correct cognitive distortions, 6) resolve issues related to guilt, blame, shame, and responsibility, 7) address feelings about abusers and other people’s
reactions to abuse, 8) improve ability to get help and support and prepare children for court, and 9) reduce symptoms and practice effective coping skills (Heiman & Ettin, 2001). Each session had a topic and sometimes more than one session was conducted on a particular topic. These topics occurred in a set order: 1) creating a safe place, 2) solidifying the group identity and uncovering abuse impact, 3) self disclosure and sharing of one’s abuse experience, 4) discharge of abuse-related feelings, 5) defining and clarifying rights, 6) clarifying issues of blame and responsibility, 7& 8) developing age appropriate behaviors and assertive skills, 9) express feelings towards offenders, 10) letting go: putting the trauma in the past, and 11) termination: a sense of accomplishment. Heiman and Ettin presented specific activities for each session. This was a structured group treatment but adjustments in activities were made as needed from suggestions and behaviors of children that participated. Clearly every group had its own unique aspects that had to be addressed by the group therapist.

Grosz, Kempe, and Kelly (2000) created and tested a treatment program for children who were victims of extra-familial sexual abuse and their families. A study to measure the effectiveness of this program involved 246 children, ages 2-14, and 323 parents. Children and families were assessed and a treatment plan was created for them that included aspects such as: 1) crisis counseling, 2) individual treatment for child and/or parents, 3) children’s treatment groups, and 4) parent support groups or referral to other resources. It was discovered that a family approach with services provided for parents along with interventions for children were essential steps to recovery. Clinical observations and participant feedback indicated that there were positive outcomes for children and parents in crisis counseling, children’s treatment groups, and parent support
groups. The goals for the children’s treatment groups were: 1) enhancing coping behaviors, 2) facilitating expression of feelings, questions and fears, and 3) teaching problem solving and prevention skills. In the beginning, it was made clear to everyone in the group that all children had experienced sexual touching however, the therapists were careful to not discuss explicit details of anyone’s abuse experiences. Clinical observations showed that the group environment brought immediate relief to the children because they realized that they were not alone in their abuse experiences. Each 90 minute session began with expressive play activities that used arts and crafts, puppets, role playing, stories, and group activities. After these activities were completed, the group moved to sit at a large table where they had a snack and talked about worries, feelings, and responses of their family and others to the abuse. This activity helped children begin to talk about these concerns and prepare some children for being present in court. Therapists also brought up relevant themes to talk about such as the responsibility of the perpetrator for the sexual abuse, and the child’s own responsibility for his or her behavior toward others.

An article by Haen (2005) described using group therapy with a very specific group of children who were traumatized by the September 11, 2001 attacks in New York City. These group therapy sessions focused on the use of metaphors, enactment, and the creative arts therapies. Therapists used metaphors to contain the anxiety of the children, and develop themes that were central to the children’s experiences. Haen explained that in general there were two phases of treatment when working with people who have experienced mass disaster and terrorism, the acute crisis stage and the working-through phase; each stage required unique interventions (Dembert & Simmer, as cited in Haen,
In the acute stage, the therapist’s main concern was to minimize the client’s distress and mobilize his or her ability to protect themselves (Raphael & Dobson, as cited in Haen, 2005). Psycho-education was often an important element of this phase as it could clarify misconceptions about the traumatic experience and prepare children and their families for possible resulting symptoms. The working-through phase occurred at different times depending on the clients. For example, Haen stated that many of the children he worked with concerning September 11\textsuperscript{th} were not able to reach this phase for many months. The children needed to feel safe before they could use the group therapy format to help them work through their trauma.

A study to compare an open versus closed format for group therapy for sexually abused adolescent girls was conducted by Tourgny and Hébert (2007). The treatment groups met for one hour, once a week, for 20 weeks. The activities, as part of a psycho-educational format, consisted of group discussions, personal testimonies and stories, individual and group exercises, and lectures. The goals of both groups were: 1) reduce negative and traumatic consequences of sexual abuse to help clients reach a normal developmental level, 2) reduce social isolation, 3) reduce shame and culpability from sexual abuse, and 4) help teenagers learn to use their individual resources and develop skills to control the repercussions of sexual abuse. There was no significant difference between the level of success for open and closed group formats used with this population.

A study by Jones (2002) connected two methods of therapy, play and group therapy, to treat children who were sexually abused. Jones explained that group play therapy was effective for many of the same reasons other forms of group therapy were effective. Group play therapy goals were to: 1) reduce isolation by learning that others
have similar experiences, 2) develop supportive relationships with group members, and 3) learn through watching others. Group play therapy used aspects of play therapy in that it was a non-directive approach that allowed children to address issues at their own pace and helped abused children be in control and feel empowered. Jones discussed typical behaviors that often arose in group play therapy and specific interventions that were used in this therapy format to address them.

2.7.8 Play Therapy

2.7.8.1 Definition of Play Therapy

Play therapy is based on the concept that playing is a form of natural self-expression for children and is a natural form of communication. Landreth (as cited in Jones, 2002) states that for children, being able to play out their experiences and feelings is the most natural and healing process that they can be involved in. There are several different forms of play therapy that include: 1) non-directive, child-centered play therapy that focuses on growth and maturity rather than on symptoms (Landreth, Homeyer, Glover, Sweeney, as cited in Dripchak, 2007), 2) Adlerian play therapy that focuses on the social interests of the child (Kottman, as cited in Dripchak, 2007), and 3) directive, gestalt play therapy that helps children reach their “authentic self” and move towards homeostasis (Oaklander, as cited in Dripchak, 2007).

Many forms of play therapy are incorporated into other methods such as psychoanalysis, client centered, and relationship therapies (Gates, 2007). Play therapy incorporates two theories of client centered therapy (CCT), 1) be non-directive and 2) give children a chance to expand their self-awareness and positive self-regard. Therapists are active in CCT play therapy to give unconditional positive acceptance and some
degree of permissiveness (Gates, 2007). In relationship therapy, the playing was focused on the present and the child’s new relationship with the therapist that helped them gain a sense of self-worth and adapt better to the realities of his or her life. The therapist actively participated in the play and used empathy as they observed, listened, and made statements of recognition. Johnston (1997) explained that the main goal for play therapy was not to solve issues but to help the child grow (Lantreth, as cited in Johnston, 1997).

There are three specific methods of play therapy that are used with traumatized children: sand play, puppets, and anatomical dolls. In sand play, the child is given a shallow tray filled with sand and miniature figures to use as a therapeutic tool (Vinturella & James, as cited in Johnston, 1997). Sand play is a non-verbal way for children to reach self-discovery by creating concrete scenes that represent personal experiences. The child can reenact past experiences and alter the outcomes if desired, a technique that is especially helpful for traumatized children (Allen & Berry, as cited in Johnston, 1997). There are often repeated themes that connect the scenes that are created in the sand (Grubbs, as cited in Johnston, 1997). McCarthy (2006) further describes sand play as body-centered due to the strong involvement of the body in using the sand. The child manipulates the sand in the same manner that he or she can manipulate themselves. The sand serves as a tool to help children filter experiences by learning to be assertive and self-aware. Sand works well as a filter for experiences because objects can disappear into it, be absorbed by it, and emerge from it. Puppets provide a safe method to help children explore traumatic issues during fantasy play and to cope with their emotions and other problems (James & Myer, as cited in Johnston, 1997). The therapist responds empathetically to both the puppets and the child on an appropriate developmental level,
while allowing the child to control the pace of the puppet play (Johnston, 1997). 

Anatomical dolls are familiar and non-threatening to the child so he or she feels comfortable using the dolls to help remember and talk about difficult issues such as trauma and abuse. Dolls provide the child with: 1) spontaneous expression of emotions, 2) sexualized play as a way to gain mastery and control over abuse, and 3) an opportunity to learn appropriate sexual behavior and prevention skills. Therapists using anatomical dolls need to remember that an observation of sexualized play with dolls isn’t a clear indication of sexual abuse. Conversely, an absence of sexualized play does not rule out the possibility of sexual abuse (Klorer, as cited in Johnston, 1997).

2.7.8.2 Play Therapy Methods/Techniques with Traumatized Children

Play therapy is a non-directive method that gives children an opportunity to acknowledge and address issues related to either trauma or abuse. Within a group or individually, children are given time to be in control of their play that helps them feel empowered, before the therapist begins to help them work through their experiences. Abused children are better able to “play out” their feelings and problems in play therapy using nonverbal methods (Ater, as cited in Jones, 2002). When conducting play therapy sessions it is important to chose materials that will: 1) encourage creative and emotional expression, 2) keep children engaged, and 3) allow for play that is expressive and exploratory (Landreth, as cited in Jones, 2002). Props such as telephones, sunglasses, therapeutic stories, puppets, sand play, nursing bottles, dishes, and utensils can be particularly helpful when working to help traumatized children (Gil, as cited in Jones, 2002). In group play therapy, the child expresses issues and feelings through play and in
addition has an opportunity to interact through play with others. During each session, children should be given time to talk about any issues or feelings raised during their play.

Gillespie (2001) described play with sand and water as therapy for sexually abused children. Water and sand were very natural and familiar to young children since water was one of the first play objects of an infant. Gillespie adapted the techniques of sand play to allow the qualities of the water and sand to be part of the therapeutic experience rather than focusing on the images created by the sand and figurines. Gillespie explained that the visual and tactile qualities of playing with sand and water together stimulated images that reflected dreams, fantasies, and feelings and could often elicit a primitive form of response through skin sensations that made children more aware of their bodies. The children became more physically involved by pushing their hands and arms into the sand and feeling that they were part of the substance. Getting the children physically involved in the play helped the therapist work with them to resolve issues that stemmed from bodily abuse. The constant sensations that children received from the sand helped them begin to experiment with different body forms, body memories, and bodily sensations and feelings. The sand play provided a safe and non-judgmental environment where they could more easily explore different sensations and re-awaken senses dulled by trauma. Hopefully over time, the traumatized children would experience sensations that triggered traumatic memories stored in body tissue. Grubbs (1994) stated that sand play was especially beneficial for sexually abused children because it afforded a safe place for open expression without intrusions of others. Grubbs believed that “once children were able to release their deepest wounds through the sand
Boyd Webb (2006) described a form of play therapy used for crisis intervention with traumatized children that combined aspects of short-term cognitive behavioral play therapy with long-term psychodynamic play therapy. In the combined form of crisis intervention play therapy, the therapist endeavored to repair the child’s faulty perceptions and resolve incorrect assumptions about the crisis or traumatic event. The therapist usually spent the first few sessions building a therapeutic relationship and teaching the child relaxation techniques and guided imagery as ways to control anxiety. The therapist also made a verbal agreement to play and talk with the child to support and help reduce the child’s worries about the traumatizing experiences. Re-experiencing traumatic events, through play, was initially scary for children but eventually the play provided cathartic relief. The therapist encouraged children to use specific toys to act out the traumatic experiences. The need for direct suggestions by the therapist during play depended on the child’s ability to deal with the anxiety induced by re-enacting traumatic events. If the child was threatened by the traumatic memories, the therapist reminded them that the trauma occurred in the past and her or she survived and was safe. Boyd Webb explained that the “ultimate goal of crisis intervention play therapy is for the child to gain some feeling of mastery over the traumatic experience through the realization that it will no longer continue to impact on her life” (Boyd Webb, 2006, p.48).

Bannister (2003) discussed an approach to play therapy with traumatized children similar to Cattanach’s (1992) foundational play therapy model. The specific approach of Bannister was to: 1) allow the child to lead but still interact with the therapist, 2) maintain
awareness of the developmental processes that occur in the child, 3) be aware that play
was a method of growth, 4) emphasize safety by using symbolism, metaphors, and
containment/boundaries, and 5) tend towards action and using the body.

Ryan (1999) discussed non-directive play therapy with maltreated and neglected
children and how symbolic play could be activated and accelerated through this therapy.
In Ryan’s “child-led” method of therapy, the child decided the issues and themes for the
session that helped children who could not directly talk to adults about their issues. Ryan
incorporated new child development information and how it applied to this population
into her methods of play therapy. In particular, Ryan found that attachment and cognitive
development frameworks and Erikson’s theories of emotional development, were
important in understanding the issues of maltreated children.

Ryan and Needham (2001) presented a case study that described Ryan’s non-
directive play therapy with a child suffering from persistent stress reactions to a traumatic
event. The intervention included eight, one hour sessions of play therapy with the child
who was accompanied by caregivers. The therapy room and materials were chosen to be
symbolically rich to trigger traumatic memories. It was important that the materials in
the therapy room were familiar and not overly stimulating because many traumatized
children were hyper-vigilant, had high anxiety levels, and had difficulty concentrating
(Ryan, 1999; Wilson et al., as cited in Ryan & Needham, 2001). The non-directive
therapy described in this article, spontaneously used cognitive processing during sessions
at the child’s pace and at an age-appropriate level.

Crenshaw and Hardy (2007) described a case that emphasized the importance of
using empathy in play therapy to help traumatized children verbalize their experiences.
The authors’ stated that play was the natural language of children, and that symbolic play allowed traumatized children to keep a safe distance from traumatic events and proceed at their own pace while working through their issues and experiences. Traumatized children in play therapy might act out scenarios that increasingly become more related to their trauma, but this could take many months. Further, the authors believe that children must trust that the therapist will care for them in an empathetic way as they face their trauma or they will not feel safe and will gain little benefit from the therapy process.

Dripchak (2007) presented issues surrounding childhood trauma and posttraumatic play (PTP) based on the theories of Milton Erickson. Dripchak used a case study to describe a specific therapy model for traumatized children and PTP. This method allowed therapists to: 1) use both non-directive and directive techniques, 2) focus on the child’s present perceptions, and 3) work towards future acceptance and resolutions. Similar to the other play therapy methods, this model allowed children to use exploratory play to feel safe in the therapy environment and set their own pace in the initial stage of therapy. Eventually, the therapist determined some traumatic themes and used the directive techniques of metaphors, fairy tales, and storytelling to introduce new ideas to the child. The therapist used other techniques including: 1) indirect suggestions, 2) refractions (the therapist talks to a toy), and 3) reflective statements, interspersed suggestions, and direct suggestions. Dripchak concluded that this play therapy model was effective and would not re-traumatize the child.

Hill (2006) explained a theoretical rationale that formed the basic foundation for a play therapy program that involved parents in the therapy process with their children. Hill worked on a team of social workers and conducted play therapy with sexually abused
children. Their therapy program was influenced by the theories and methods of filial therapy that trained parents to use non-directive play therapy techniques and serve as therapists for their children. One difference between the specific therapy method used in this study and filial therapy was that instead of training parents to serve as therapists for their children, this method worked with the parents and the children at the same time. This change allowed parents to meet with the therapist without their children, as preparation for the session. These discussions gave the therapist a chance to acknowledge the significant impact the sexual abuse had on the parents and to include a wider group of people to support the parents. The therapists also had a chance to observe and model therapeutic approaches for the parents. Hill discussed critiques and limitations of involving parents in therapy and presented two cases as examples.

A study by Scott et al. (2003) measured the effects of individual, client-centered, play therapy on children who were sexually abused. The study involved 26 children, ages 3 to 9, that participated in play therapy and were given pre-and-post therapy tests. The hypothesis was there would be improvements in self-esteem, self-concept, social competence and adjustment over the course of therapy. In general, the results indicated mixed support for play therapy efficacy with no statistical significance for any measured effects. The results did indicate that children felt more capable of performing at the end of sessions, suggesting that their sense of competency increased during therapy.

Griffith (1997) described another treatment model for using play therapy with sexually abused children to help them express themselves and release emotional distress. The therapeutic relationship was emphasized as was the importance of the therapist’s
empathy and support of the child as he or she made changes and grew. Griffith described the play therapy room and props in detail that allowed for extensive symbolic expression.

A longitudinal treatment outcome study conducted by Reyes and Asbrand (2005), provided play therapy for 18 children ages 7-16, over the course of 9 months. The study measured trauma symptoms of the children before and after play therapy. The results indicated that the symptoms of anxiety, depression, post-traumatic stress, and sexual distress decreased significantly after 6 months of therapy.

Play therapy with a school aged child who experienced early trauma and loss was described in detail by Stein (2002). Due to trauma and loss early in life, the child had developmental delays in his speech, cognitive abilities, frustration tolerance, and object relations. Over time the child was able to, with the therapist as a constant object, re-enact his early trauma and loss, make significant improvements in his previously delayed development, and begin to play in a symbolic and expressive way.

2.7.9 Creative Arts Therapies

There is a great deal of research and literature that focuses on using creative arts therapies to treat both traumatized children in general and specifically children who are sexually abused. Most creative arts literature focuses on therapy using music, art, dance/movement, and drama/psychodrama. The unique quality of creative arts methods, compared to other forms of therapy, is the use of non-verbal techniques for expression and exploration in therapy. Valler (as cited in Pifalo, 2002) explains that verbal therapy used in isolation is often met with resistance by victims of sexual abuse because their abuser or other trusted adults use words to lie, threaten, or mislead them. The following
is a review of specific techniques that are unique in each individual method of creative arts therapy (music, art, dance/movement, and drama/psychodrama).

2.7.9.1 Music Therapy

2.7.9.1.1 Definition of music therapy.

Music therapy can be defined as music within a therapeutic relationship to target emotional, cognitive, physical, and social needs of clients. Music therapists make assessments by observing their client’s musical responses and then provide interventions. Music therapy interventions include: 1) music improvisation, 2) receptive music listening, 3) song writing, 4) lyric discussion, 5) music and imagery, 6) music performance, and 7) learning through music. Music therapy provides non-verbal methods of communication for clients who are not able to verbally express themselves. Music therapists work with people with diverse issues: people of all ages with mental health issues, developmental and learning disabilities, aging related issues, substance abuse, brain injuries, physical disabilities, and acute and chronic pain. These therapists work in facilities such as medical and psychiatric hospitals, outpatient clinics, rehabilitation facilities, correctional facilities, schools, and various types of day care treatment programs (American Music Therapy Association, nd).

The natural movements of the body have rhythmic qualities that originate from emotional and motivational impulses that innately connect people to music. The basis of music therapy is rooted in this innate music held in the brain even after serious trauma and impairment of the nervous system (Darnley-Smith & Patey, as cited in Robarts, 2006). Music therapists can use the client’s natural responsiveness to music to develop a relationship based on his or her needs. Musical instruments are considered as extensions
of a person’s feelings and gestures, and the music brings sensations, feelings, and behaviors into playing with music (music play). Clients involved in music therapy learn to experience themselves in new ways through the music, and they can also use the music and instruments symbolically, for example to create a safe barrier. If musical play became uncomfortable for some clients the therapist can intervene with verbal discussions of the experience (Robarts, 2006).

Music therapy effectively deals with resistance, denial, and low self-esteem; characteristics that cause difficulty when treating the emotional pain connected with abuse. This process of therapeutic change is dependent both on the therapeutic relationship between client and therapist, and the music. In music therapy clinical improvisation is used to: 1) examine and acknowledge the internal, emotional world of the client, 2) substitute sound for verbal dialogue and the therapeutic relationship, and 3) to understand, reflect and interpret verbally or musically the significant issues faced by the client (Rogers, 1993).

2.7.9.1.2 Music therapy methods/techniques with traumatized children.

The review of literature on music therapy with traumatized children published in the past ten years indicated that there was limited information in this area. To present relevant music therapy techniques, foundational literature on music therapy with children, and literature on music therapy with adult survivors of sexual abuse was included.

Robarts (2006) discussed music therapy in general and illustrated this method by describing the case of a sexually abused girl that was in treatment from age 7 to 14. Robart’s approach was to first create a safe environment with boundaries that allowed the girl to explore her emotions. Music allowed Robarts to work with the girl’s feelings,
gave her new experiences of these feelings, and helped her join in a relationship with the therapist. The girl progressively felt more comfortable, and through exposure to music, would play, touch, and explore these sensations as they occurred as part of her experiences and life overall. Over time, the girl became tolerant and trusting and actually started to play music. Music therapy allowed her to develop important skills that she had not gained during her abusive past. Music played a “vital role in helping her recover—or rather build—a bodily, emotional, and physical sense of self” (Robarts, 2006, p. 264).

Rogers (1993) discussed research in music therapy with sexually abused children. Music therapy with clinical improvisation helped sexually abused children have direct experiences with their emotions by projecting them onto musical instruments. For example, improvisation helped a child face an argument with a family member by playing an instrument with the emotions related to that situation. A child could tell his or her therapist how to play an instrument to reflect another family member in the same situation. Specific instruments were sometimes chosen to represent each person and the way that the child played each instrument usually had symbolic meaning. Often the musical improvisations of sexually abused children were a confusion of chaotic sounds that easily expressed their ambivalence and mixed emotions. Music therapists could use the symbolic roles of instruments and boundaries to create feelings of safety and a framework for the client. Methods used to establish boundaries included: 1) use the same room for all sessions, 2) meet at the same time of day, for the same length of time, 3) have the same instruments always available, 4) stop intrusions and interruptions during sessions and 5) prepare for holidays and their effects. Since sharing instruments was an intimate form of communication, abused children could interpret this sharing as invasion
into their personal space. Music therapists felt that it was important to respect children’s physical boundaries and respect their discomfort with touch. Sometimes, over the course of therapy, the client’s increase in willingness to share instruments indicated an increase in trust and ability to positively interact.

The role of improvisational music therapy to help expose, deal with, and heal the traumatic experiences of sexual abuse was presented by Amir (2004). Musical improvisations were defined as “musical acts that can bring out hidden, unconscious material and make it conscious and available to the client” (Amir, 2004, p. 96). Music therapy provided a safe environment, unlike the original traumatic environment, where clients could re-experience their trauma. Music directly accessed emotions and guided the client and the therapist to areas of the unconscious where traumatic memories were stored. Although memories of trauma could be painful and upsetting, music had the potential to “convert feelings of shame, anger and helplessness into a creative force that eventually brings power and healing” (Amir, 2004, p. 97).

MacIntosh (2003) presented literature on the efficacy of musical interventions for survivors of trauma, and how she alters psychotherapy techniques for use with sexual abuse survivors. MacIntosh explained that music stimulated this population because it was a non-verbal communication that they could safely use to express traumatic material. They might have experienced the trauma at a preverbal developmental level and stored the experience as sensations or emotions rather than in words. Regardless of the age when trauma occurred, memories were often too painful to approach on a verbal level; music provided a release of traumatic experiences that might not otherwise have surfaced. Music therapy helped survivors of sexual trauma become aware of connections
between their mind, body, and spirit. Music bridged defense mechanisms and
reconnected their bodies and minds that were separated during trauma. Recent research
comparing psychoneuroimmunology and music revealed that physical health and immune
function were improved by musical interventions in therapy (MacIntosh, 2003).

2.7.9.2 Art Therapy

2.7.9.2.1 Definition of art therapy.

Art therapy is defined by the American Art Therapy Association (AATA) as “an
established mental health profession that uses the creative process of art making to
improve and enhance the physical, mental, and emotional well being of individuals of all
ages” (American Art Therapy Association, AATA, nd). Art therapy is based on the
belief that the creative process of art can heal and enhance life. It is easier for children to
create art to communicate difficult issues, reduce stress, and reconcile feelings. Art
therapists treat clients with: 1) a variety of mental and emotional problems and specific
disorders, 2) substance abuse and other addictions, 3) family and relationship issues, 4) abuse, 5) social and emotional problems due to disability and illness, 6) trauma and loss,
7) physical, cognitive and neurological issues, and 8) psychosocial problems related to
medical illness. Art therapy can be directive or non-directive in nature and done with
individuals or a group. Art therapy is conducted in numerous settings including
hospitals, clinics, public and community agencies, wellness centers, educational
institutions, business, and private practices (AATA, nd).

Clements (1996) describes art therapy as a form of communication that helps
clients gain insight through art or other visual imagery as a tangible medium, and
supports them to unconsciously and consciously express themselves and work toward
change. Art therapy is a method that guides clients to explore inner conflicts and problems rather than a method for denying these issues and experiences. The therapy is conducted using three factors: 1) the relationship between the client and therapist, 2) the creation process, and 3) the art that is created. The process of therapy includes both the client creating art and the therapist discussing the client’s art to see how it reflects the client’s feelings or is related to his or her life situation. Children often need help and emotional support during the art making process.

Art therapy has a strong psychodynamic framework originally based on the work of Jung, Winnicott, and Klein (Case & Dalley, as cited in Meekums, 2000). The degree that art therapists consider themselves psychotherapists varies a great deal (Meekums, 2000). Key concepts in art therapy include: 1) symbol formation, 2) object relations, and 3) play and the inner world of the individual (Case & Dalley, as cited in Meekums, 2000). The iconic nature of art therapy is believed to allow access to early experiences while bypassing cognitive processes. The physical projection of art onto paper or another medium creates a container for the psychic material. The creative material that is projected during the art project is assumed to arise from unconscious thought not accessible with words. Once the material is contained in the form of art, it can be worked with immediately or left alone to be discussed or added to later (Minde, as cited in Meekums, 2000).

2.7.9.2.2 Art therapy methods/techniques with traumatized children.

The American Art Therapy Association defined the following goals for art therapists working with traumatized children: 1) encourage them to share whatever they want through their art work, 2) use art activities to increase self-reliance and problem
solving, 3) introduce different art materials, 4) teach new art skills, and 5) stimulate them to make decisions about what to create. Once significant feelings and experiences were expressed in art therapy it was important to be sure that the child was calm and in control before ending a session; using a closing activity or having the children help clean the space often worked well (AATA, nd). As previously mentioned, art therapy with this population used structured (directed) and unstructured (non-directed) activities. Unstructured activities encouraged children to use their imagination to create art of their choice. Structured activities were particularly helpful with shy or withdrawn children. For example, a therapist might ask a child to draw a picture related to a specific theme common in abused children such as worry or safety. Another structured activity involved the creation of an imaginary safe place where the child could go when scared or upset.

The American Art Therapy Association recommended the following art supplies for use in therapy with this population: 1) materials for drawing that allow for control and detail such as pencils, colored pencils, oil pastels, felt pens, and paper, 2) materials for painting such as watercolors, 3) paints for the children to express experiences, stories, and emotions through use of color and brushstrokes, 4) materials for collages like pre-cut magazine images, 5) construction paper, tissue paper, regular and glitter glue, 6) string/yarn that are materials that are easy to control, and 7) modeling materials such as different types of modeling clay and water-based clay that allow the child to work in three dimensions, and destroy and reconstruct art work. These materials provided structure and helped access the child’s imagination (AATA, nd).

Clements (1996) explored the possibility of using spontaneous art therapy images in the diagnosis of sexually abused children and presented art images from her therapy
with this population. Clements also compared her findings with others in attempts to show the importance of art therapy in the treatment of sexually abused children. It was believed by Clements and Johnson (1987) that spontaneous art therapy with abused children could access blocked thoughts, feelings, and traumatic memories that were stored in photographic form. Clements made the point that art therapists might receive referrals of children who have not disclosed their sexual abuse history. They could explore why the child was silent about the abuse through either examination of art work for visual images that indicated issues or by asking the child questions about the art to gain more information. Storytelling in the third person could be used to ask the child questions about his or her art. When the child was ready to communicate, the therapist could re-address the story as a possible reality for the child. A helpful component of art therapy was that art work created in one session could stay hidden until a later session when the child was able to acknowledge the real content. Art therapists considered the process of creating art work equally as important as the content of the images created. They believed that the creative process provided a channel for the abused child to express his or her overwhelming feelings, and provided distance or a barrier from the actual content of the art work until the child was ready to address it. By creating art, the child brought experiences or memories out of his or her unconscious to begin the healing process. Another approach was to give sexually abused children complete control over the images they created in terms of color, materials, size, and aesthetics (non-directive art therapy). If having total control was overwhelming for the child, due to a lack of control during the abuse, the therapist limited the amount and type of art supplies that were
available. Art therapists doing non-directive art therapy continually provided support and encouragement while the child created spontaneous art.

Eaton, Doherty, and Widrick (2007) reviewed published, peer-reviewed literature that described the use of art therapy for traumatized children, to review the efficacy of art therapy for this population. The results indicated that art therapy was used successfully in numerous contexts as a treatment modality for traumatized children. The art therapy techniques and structure included developing a therapist-client relationship through creating art and storytelling (Coleman & Farris-Dufrene, 1996, Moschini, 2005 & Simonds, 1994, as cited in Eaton et al., 2007). In the beginning of the therapy process, the child created art work with the therapist who provided appropriate materials and encouragement. As therapy continued, the therapist asked the child to tell a story about the art he or she created while the therapist helped with the interpretation of the story. The storytelling allowed for fantasy and reality to be separated, which led to self-discovery and cathartic release. The child was given the opportunity to learn how to cope with the reality of the trauma and related feelings (St. Thomas & Johnson, as cited in Eaton et al., 2007).

Buckland and Murphy (2001) conducted art therapy with young girls who were survivors of sexual abuse. Some activities that they used were: 1) large group paintings by all the children and the therapist, which symbolized the shared journey, 2) making paintings that showed how the children felt towards their abusers, and 3) sitting at a table together with snacks and drinks for a discussion and processing of the group.

The process of creating art reduced anxiety and helped clients discuss issues more openly than possible in a purely verbal session. Pifalo claimed that “the very act of engaging in the creative process facilitates the release of energy through bodily action and movement” (Pifalo, 2002, p.13). An important benefit of art therapy was that a client might feel safer drawing his or her secrets rather than telling them in words. Victims of sexual abuse were often threatened to not talk about the abuse to avoid consequences. Also, creating art acted as a barrier between the child and reality that the child felt he or she could control. They could choose to lower or raise the barrier depending on how threatening the information was for them. They were allowed to decide if they wanted to claim the work as their own, claim that the art was just a picture, or be willing to explore issues in more depth. The client controlled his or her art by being able to erase, paint over, tear, or fold any information that was too painful to deal with at that time. They also described specific activities and art materials used with this population.

Gil (2003) explained the success of using both art and play therapy with sexually abused children. Specifically, art therapy allowed children to create images that expressed their perceptions of themselves and the world around them. The act of creating the art was very therapeutic for the child. A concrete work of art with specific dimensions and boundaries on paper contained thoughts and issues that might have felt overwhelming, but were now more manageable when contained in the artwork.

Steele (2003) presented a structured art therapy intervention method that exposed clients to traumatic memories through: 1) drawing, 2) developing a trauma narrative and 3) cognitive reframing. He explained how the drawing component of this intervention was used as a “form of exposure to assist children in constructing trauma narratives while
drawing activities used with this population needed to relate to the main themes of trauma such as drawing “what happened” and “what the victim looked like at the time” (Steele, 2003, p.144). Although drawing activities could be non-directive, specific instructions were often used to direct creation of a story or narrative.

Talwar (2007) created and described a therapy protocol entitled Art Therapy Trauma Protocol (ATTP), in an article that addressed the role of memories and emotions in trauma and the theories of art creation and brain functioning. This protocol was created to address the non-verbal, somatic memory of traumatized people by using both the right and left brain. Art Therapy Trauma Protocol made use of both hands to process traumatic memories, used positive and negative cognitions, rated negative cognitions, and found the cognitive emotion within the body using EMDR methods. This form of therapy combined client-centered and cognitive behavioral methods to address the affective issues experienced by the client. Clients were taught to create their own methods of problem-solving, learn to understand their emotional responses, and successfully access images of safety.

In therapy using ATTP, clients painted on a large 22 by 29 inch piece of paper taped to a wall or an easel that allowed them to stand, walk back and forth, and use their
whole bodies while painting. When they were finished painting, they were requested to talk about the strongest emotion associated with the painting or parts of the painting. Next they were asked to think of both negative and positive self-representations and cognitions for each memory and rate their validity on a scale from 1 to 7. The whole process was repeated each time on a separate piece of paper, switching the hand used to paint, until the memory had been completely worked through and there were no distressing feelings when they recalled the traumatic experience. Unfortunately, ATTP in the form described here has only been used for adult clients. However, the author stated that modified versions were used under supervision for both children and adolescents but discussing the issues in using ATTP with these ages was beyond the scope of this particular article (Talwar, 2007).

2.7.9.3 Drama Therapy and Psychodrama Therapy

2.7.9.3.1 Definition of drama therapy and psychodrama therapy.

Psychodrama is related to traditional theatre with the exceptions that there is no script and the actors play out scenes from their own lives. The therapist acts as the director of the show and orchestrates actions that are decided by the main character. Co-therapists or other group members act as assistants in the show. Over time, psychodrama has become principally a group psychotherapeutic method that enhances the importance of group relationships. Psychodrama is also practiced in an individual format using toys, dolls, puppets or objects such as pillows to represent other people, animals, or places. Psychodrama is used with a variety of populations such as adult survivors of sexual abuse, people with substance abuse issues, sexual abusers, and people suffering from terminal illnesses. This form of therapy can also be combined with other therapy
methods such as play therapy. Psychodrama has a strong foundation in developmental psychology and uses techniques such as doubling, mirroring, and role reversal (Carbonell & Parteleno-Barehmi, 1999), to help clients revisit previous stages of development to heal and re-learn certain skills (Bannister, 2003).

Doubling is a technique mothers naturally use when trying to figure out what their infant needs. They replicate the infant’s expression and make suggestions as to how the infant might be feeling. In psychodrama, a group member will get close to the main person acting out and copy his or her movements or body position, and try to verbalize the feelings he or she thinks the member is expressing. This action method is used in non-verbal forms of therapy and is based on the belief that the body and mind are closely connected. Mirroring is another technique similar to doubling that is used by caregivers. In therapy, group members mirror the actions and words of the acting member to help them develop a broader view of expressing their feelings and become aware of the perceptions of others (Bannister, 2002; Carbonell & Parteleno-Barehmi, 1999). Research in this area presents applications of psychodrama with various populations (Bannister, 2003). Other psychodrama activities include: 1) scene setting, 2) “empty chair” work, 3) future projections, 4) surplus reality, 5) personification, 6) soliloquy, and 7) chorus. Children in psychodrama therapy groups take turns sharing their dramas each week so every child has at least one chance to be the protagonist of his or her own drama (Carbonell & Parteleno-Barehmi, 1999).

Drama therapy is loosely defined as using drama as therapy and is influenced by theatre and dramatic literature such as Shakespeare’s plays, Greek myths, drama, and fairytales. Unlike psychodrama that has one main character working out personal issues
with the support of the group, in drama therapy the group is often homogeneous and works together on common issues using dramatic distancing and symbolic identification (Bannister, 2003). The clients in a group act out a situation of one group member while that member watches (Citron, 2002). Drama, like other forms of creative expression, provides many layers of experience that create distance for the individual from the content of the activity (Jennings, as cited in Meekums, 2000). Jones (as cited in Meekums, 2000) presents nine core processes in drama therapy that are: 1) dramatic projection, 2) therapeutic performance process, 3) dramatic empathy and distancing, 4) personification and impersonation, 5) interactive audience and witnessing, 6) embodiment, 7) playing, 8) life-drama connection, and 9) transformation. Drama therapy is influenced by the Sesame method, initiated by Lindkvist that places emphasis on the body and is mainly non-verbal (Pearson, as cited in Bannister, 2003). The non-verbal techniques of drama therapy help children who have difficulty verbally expressing their experiences. If needed, drama therapists use props such as puppets and masks as a method of distancing for the client (Landy, as cited in Meekums, 2000). The goal of drama therapy is to give the client an opportunity to view the creation and establish a relationship to it, using new insights, experiences, and perspective (Jennings, as cited in Meekums, 2000). Drama allows clients to change the way they look at their lives and the world around them.

2.7.9.3.2 Drama therapy and psychodrama therapy methods/techniques with traumatized children.

Of particular interest to trauma work within drama therapy is the process of embodiment that describes how a client physically expresses and experiences information
at the present time. Jones (as cited in Meekums, 2000) believed that using the body in
drama therapy enhanced the intensity and nature of the client’s involvement and
embodiment, and helped clients who had experienced trauma work on issues specific to
his or her body. Although trauma could inhibit spontaneity, being involved in
psychodrama helped increase the client’s spontaneity and eventually helped reduce the
psychological impact of trauma (Kellermann, as cited in Bannister, 2002).

Citron (2002) used psychodrama in the treatment of sexually abused children
under 18 and their families in Sweden. She found psychodrama to be a helpful approach
in groups because it gave the participants a chance to demonstrate abusive experiences in
a realistic but safe and controlled way. The clients could work in the present to address
trauma that happened in the past and gain the ability to differentiate between past and
present. She had the group act out a situation or experience of a group member who was
the main character of the story. She used puppets, dolls, and stuffed animals instead of
role playing because these props allowed the clients to be more in control as they worked
through painful experiences. Using these objects was also easier than role playing for
very young children. The puppets served as a mirror or an object for children to project
their feelings onto that created a sense of distance and safety in the therapy process. The
member who was the main character was acting partly from his or her unconscious.
However, this process could be overwhelming and cause the client to dissociate. If
dissociation was a risk, Citron had the member sit out and watch as the remainder of the
group acted out the experience. A client who sat out might gain awareness of denied and
repressed feelings and thoughts. This key member was allowed to verbalize actions that
they wished for in both the drama and in real life. The group supported enactments of a
“rescue scene” wherein the key member assumed different roles and could change the outcome of the story. Citron was always careful to check in with group members to insure a sense of safety and comfort with the process. In her psychodrama groups, Citron also used activities such as: 1) giving children cards with faces that represent different feelings and having them choose the card that reflects how they feel that day, 2) passing a ball or stuffed animal around the group to learn everyone’s names, and later using it to conduct a verbal check-in with each member, 3) using common children’s games to give the children a chance to move around, and 4) using fairy tales and rhymes to address certain themes and issues. A child’s body awareness and sense of boundaries was strengthened using a rhyme in concert with a specific movement. The therapist selected fairy tales that involved an abused character and addressed the issues involved in this type of experience. Each child in the group had a chance to act out his or her abusive experience and to change the outcome as the child wished. Sometimes the leader introduced a drama topic and encouraged all members to contribute ideas. The leader brought up themes that were common issues for this population as a teaching opportunity, particularly for sexual education. The process of acting out experiences was very cathartic and encouraged disclosure of abuse by children (Citron, 2002).

Herman (1997) presented a case-study of her work using video versions of traditional children’s fairy tales with a pre-school aged child who was sexually abused. Videos of traditional fairy tales provided an appropriate context for the expression of covert sexual themes based on the child’s previous sexual abuse. In this specific case study, Herman provided toys and dolls for the child to use in creating and acting out dramas. Fairy tales contained metaphors that an abused child could use to create distance
from painful material (Stirtzinger, as cited in Herman, 1997). Creativity provided the therapist with insight into the child’s unconscious (Davis, as cited in Herman, 1997). Children easily dramatized characters and situations from their own life to create dramas (Spolin, as cited in Herman, 1997). Covert sexuality themes within fairy tales increased their usefulness in the treatment of sexually abused children. Herman suggested using a combination of drama and storytelling techniques, within the framework of video fairy tales. The therapist used themes and typical characters in fairy tales to help the child reveal the abuse.

Carbonell and Parteleno-Barehmi (1999) evaluated the effectiveness of psychodrama in treating traumatized middle school age girls. This study offered clear guidelines for using a warm-up, middle and closure format for therapy with any group of traumatized children. The researchers randomly assigned the children to either a control or treatment group and measured pre and post treatment adjustment. Interviews were also conducted with the children after the study was completed to gain an understanding of their experience. Following psychodrama, the girls had significantly reduced levels of withdrawn behavior and anxiety/depression. The interviews reinforced the effectiveness of psychodrama and group participation in resolving trauma and creating an increase in feelings of competence and self-efficacy. Carbonell and Parteleno-Barehmi outlined the group structure and activities used during psychodrama with this population and offered guidance to therapists using this method with vulnerable populations. Each treatment session had warm-up, action, and sharing phases with a balance of structure and spontaneity to ensure safety and competence. The warm-up phase was used to: 1) build group cohesion and trust, 2) allow children to experiment with different activities that
would be used in future sessions, 3) introduce group members, leaders, and present the
general format and parameters of the sessions, 4) create group rules and norms to help
members learn to trust and respect each other and maintain confidentiality, 5) give all
members the chance to express themselves, and 6) help children discover commonalities
between one another. The action phase allowed the children an opportunity to: 1) reenact
the traumatic event by showing and telling about what occurred, 2) express how they feel
non-verbally, 3) stay distant from their feelings because it is only a “play”, and 4) reenact
their trauma to get in touch directly with their senses and create an emotional connection
to the traumatic experience. Reenactment could appear threatening, but the children had
complete control over how they addressed the trauma through drama, which was much
different than the actual traumatic experience. Each child decided who would play the
parts in the drama, how the roles were expressed, the setting, and the outcome.
Psychodrama allowed children to address fears in a safe environment where they had
support and specific tools to alter their experience. In the sharing phase, all participants
talked about experiences and feelings that occurred during psychodrama. Termination
activities focused on containment, connecting to others, choice, and self-efficacy that
were essential in the healing process of trauma. Overall, psychodrama created a
framework that allowed traumatized children to discuss and express their fears, emotions,
possibilities, and alternatives.

2.8 Body-based Therapy Methods/Techniques used with Victims of Trauma

The literature on body-based therapy methods with traumatized individuals is
clearly relevant to this research study. Unfortunately, only a limited number of articles
specifically addressed using body-based therapy methods with traumatized children, the
focused population in this study. Therefore, the following is a limited overview of the application of body-based therapy methods with trauma victims in general.

2.8.1 Body Psychotherapy

In a theory and practice text Aposhyan (2004) suggested body-mind psychotherapy for specific populations and issues such as trauma. Aposhyan stated that an important goal to address with clients recovering from traumatic experiences was restoring a sense of bodily safety. In contrast to this goal, some other therapeutic approaches focused on “creating safety” in the less controllable environment outside of the body. Body-mind psychotherapy treatment was initiated by helping the client identify areas of safety in his or her bodies that could subsequently provide support for the less safe areas. When the client recognized bodily centers of fear he or she could learn to listen to these fears, express them, and come to the realization that the threat was gone. The act of creating physical support and protection helped to convince the body that it was possible to feel safe in the future, unlike the past. The term “shock”, as used in body-mind psychotherapy, defined two responses: 1) the nervous system response to danger manifested in an increase in heart and respiratory rates and increased muscle tone, and 2) the nervous system response to danger manifested in body stillness and alertness to surroundings. Body-mind psychotherapists believed that by defining the physical responses, clients learned to recognize their own traumatic responses and work towards developing embodiment. This recognition was an important step because people involved in a traumatic experience often dissociated and did not pay attention to the state of their bodies. Aposhyan explained that repeated experiences of trauma or even one incident of extreme trauma, led to residual shock inside the body that could be triggered
by even ordinary events. Body-mind psychotherapists instructed clients to check in on the effects of shock on all their body systems, to learn how to evaluate the presence and degree of shock. The ability to recognize different levels of shock in the body allowed clients to be more present and embodied rather than detached or in shock. Aposhyan gave specific details on techniques that were used to help develop embodiment, and engage different nervous systems components.

Price (2004) researched body-oriented therapy for adult women in recovery from childhood sexual abuse and compared the effects of two body therapy approaches: 1) body-oriented therapy that combined hands-on bodywork and verbal therapy to focus on somatic and emotional awareness, and 2) standard massage with soft tissue manipulation that involved holding and moving soft tissue, and/or applying pressure to the body (American Massage Therapy Association, as cited in Price, 2004). Both interventions used therapeutic touch and the hands-on techniques to carry out the massage aspects of the therapy. However, the massage group received only standard, spa-type massage for eight weeks while the body-oriented therapy group received a more complex and individualized intervention. The massage therapists conducting the standard massage group worked with participants clothed to reduce anxiety and discomfort connected to nudity and touch, a particular problem for sexually abused clients. The actual massage and providing a sense of safety were the most important elements of the massage therapy intervention. Safety for both the participant’s physical and emotional comfort was monitored through systematic check-ins to assess her level of comfort. The body-oriented therapy group participated in a type of therapy consisting of: 1) massage, 2) verbal components to explore somatic and emotional awareness, 3) body awareness
exercises, 4) delving, and 5) homework. Delving was a body self-awareness process used specifically for bodywork therapy with two main components: 1) bringing awareness to the internal body, and 2) maintaining a mindful presence in terms of the internal body. There was several body changes measured for the participants in both forms of therapy that included: 1) psychological symptoms, 2) physical symptoms, 3) body connection indicators, and 4) the subjective experience of body therapy. The results revealed significant changes, over time, on all outcome measures for both massage therapy and body-oriented therapy participants. There were no statistically significant differences between the two forms of therapy. Importantly, the body-oriented therapy approach supported somatically-based insight and affected recovery from sexual abuse by increasing self-knowledge, and the massage therapy approach increased self-care behavior and affected recovery by motivating engagement in psychotherapy.

2.8.2 Massage Therapy

Becker (2003) conducted research to examine two aspects of massage therapy: 1) the perspective massage therapists have on treating survivors of trauma, and 2) the demographics of clients who experienced psychological trauma. The results of this study revealed that over 70% of the massage therapist’s clients were referred to treat psychological trauma and over 90% of their clients at least talked about psychological trauma during therapy. Despite the high percentage of clients with exposure to psychological trauma, only 45.5% of massage therapists had received formal training for working with trauma victims. Usually this training did not occur in massage therapy schools but was taught instead in outside seminars. Becker’s results supported the
importance of increasing the scope of training in both massage therapy and psychotherapy to effectively treat this population.

Very little research was available on the effectiveness of massage therapy, often called bodywork, on psychological disorders (Becker, 2003). Most of the research that focused on using massage therapy to treat trauma, described a combination of massage therapy and other forms of therapy. An example of this work was Upledger’s studies that demonstrated that CranioSacral therapy effectively reduced the symptoms of PTSD in Viet Nam veterans (Upledger, nd). The work of Fitch and Dryden (as cited in Becker, 2003) discussed using massage therapy with clients suffering from PTSD. In their opinion, the specific type of massage therapy that was used was less important than the structure of the sessions. They suggested that each massage session should have three parts: 1) a beginning, 2) middle, and 3) an end. At the beginning of each session the therapist established boundaries, safety guidelines, and goals. The middle segment contained experimentation to gain information on the type and location of touch that felt safe for the client. The session should end with time for the client to talk about feelings that arose during the session, and talk with the therapist about what they both believe should be addressed in psychotherapy. Benjamin (as cited in Becker, 2003), presented guidelines for providing massage therapy with victims of sexual abuse. Benjamin believed that massage therapy with this population provided a chance for them to experience non-sexual and non-aggressive touch. Also, massage therapy helped clients learn to establish boundaries and limits in terms of touch by being in control of where they were touched by the therapist and how much pressure was used. The increased ability to be in control of their bodies led to improvements in body-image, and a decrease
in feelings of shame. During massage therapy, Benjamin noted that sexual abuse victims had a tendency to dissociate. The therapist needed to encourage them to stay present in their bodies and help lead them toward control and the establishment of boundaries.

2.8.3 Sensorimotor Psychotherapy

Sensorimotor psychotherapy integrates sensorimotor processing with cognitive and emotional processing to treat trauma (Ogden & Minton, 2002). This method of therapy uses the body as the main entry point to treat the effects of trauma on the body and help address emotional and cognitive processing of trauma. Sensorimotor psychotherapists aim to keep the client’s arousal level within a tolerable range to expand his or her integrative capacity (Ogden & Minton, 2002). Sensorimotor psychotherapy combines techniques from cognitive and psychodynamic therapies with somatically based methods. Therapists work on both the cognitive and the sensorimotor levels to help survivors of trauma attain a higher level of integrative capacity and realization. Realization is reached when a survivor of trauma accepts that the trauma occurred in the past. Also within realization, the individual reorganizes old tendencies and develops new cognitive, emotional, and physical behaviors that support more adaptive responses.

Ogden, Minton, and Pain (2006) continued to expand their initial work on the effects of trauma on the body and also the use of sensorimotor psychotherapy as a form of treatment. In sensorimotor psychotherapy, clients were taught to shift their attention from the past to the present to focus more internally. Trauma survivors developed the skill to narrow their focus; this allowed them to assimilate and they began to successfully integrate information when they became hyper-aroused or overwhelmed emotionally. Survivors of trauma, who got overwhelmed by a small amount of internal awareness,
were taught to expand their focus to include information outside their awareness that might provide stability for them. In sensorimotor psychotherapy, clients learned to focus on good feelings in their bodies and positive thoughts and images rather than concentrating on the painful feelings and traumatic activation in their bodies such as increased heart rate.

Ogden, Minton, and Pain (2006) described how sensorimotor therapists paid attention to the communication of the body. They tracked the non-verbal aspects of the client’s experiences and read his or her body to observe both persistent action tendencies and body postures. The information expressed by the client’s body helped the therapist learn more about his or her long held beliefs and emotional tendencies. The therapist communicated the most important information from observations to the client, so the client could be more aware of his or her actions. Mindfulness techniques were used in sensorimotor psychotherapy to help the client become aware of and focus on his or her internal experiences of thoughts, feelings, sensory perceptions, inner body sensations, muscular changes, and movement impulses. Therapists structured tasks to both gain insight themselves and to help the clients gain new insight into the effects of their trauma, their behavior tendencies, and how they organized their experiences. Touch was used in numerous ways in sensorimotor psychotherapy to: 1) activate nerve sensations to increase body awareness, 2) create new somatic resources, 3) make the individual aware of already present resources, 4) aid in the learning of new behaviors and postural patterns, and 5) help the client become aware of comfortable touch and his or her body boundaries. Even though touch was often used, the authors advised using touch with caution (Ogden, Minton, & Pain, 2006).
The work of Ogden, Minton, and Pain (2006) described how all forms of sensorimotor psychotherapy followed the format of phase-oriented treatment approaches with set phases that include goals, interventions, and skill building requirements. The three phases of sensorimotor psychotherapy with trauma survivors were: 1) symptom reduction and stabilization, 2) treatment of traumatic memory by overcoming fearful avoidance of these memories, and 3) work on personality integration and rehabilitation. In phase 1, clients learned to recognize triggers, limited their access to over-stimulating situations, and changed orienting tendencies. These skills helped them increase their bodily awareness so they began to recognize warning signs of hyper-arousal and used somatic resources to cope with situations. In phase 2, the physical sensations, sensory intrusions, emotions, and actions that were a part of memory fragments were addressed. Clients worked to “identify and embody the resources that helped them cope with traumatic events and learn to use the body to discover actions that provide a sense of mastery even with remembering those past traumatic events” (Ogden, Minton, and Pain, 2006, p.187). By phase 3, clients had developed important skills, an awareness and confidence in their bodies, and experienced feeling empowered towards traumatic memories. At this point, they were ready to work on the enrichment of their daily lives.

In other work, Ogden, Pain, and Fischer (2006) described a sensorimotor approach to treating trauma that focused on dissociation. To address implicit aspects of traumatic memories the therapist asked the client to focus on the non-verbal residue of the trauma. The somatic bottom-up intervention of sensorimotor psychotherapy was combined with traditional top-down interventions to help clients transform their trauma narrative and aided in the development of a somatic sense of self. The authors proposed
that by attending to their client’s body directly, it was easier to address the more primitive, automatic, and involuntary functions of the brain that were connected to traumatic and post-traumatic responses. Sensorimotor psychotherapy helped clients engage their mind to observe interactions between their perceptions, emotions, movements, sensations, impulses, and thoughts. By teaching clients to notice their experiences on a body level they learned to notice their “innate somatic regulatory capacities” or resources, that could then be evoked easily through the breath or body movements (Ogden, Pain & Fischer, 2006, p. 267). This integrated approach helped clients regulate their physical experiences to feel grounded, and connected to the present.

2.8.4. Somatic Trauma Therapy, Somatic Psychotherapy

Somatic trauma therapy was a treatment model originally created by Rothschild (2000, 2003) from her work with victims of trauma and PTSD specifically. Rothschild described the theories and practice of somatic trauma therapy that addressed her main concern to make trauma therapy safer. Rothschild stressed the importance of addressing both the body and the mind in trauma therapy by combining relevant techniques from both verbal and body-based psychotherapies. Somatic trauma therapy used the body and several techniques to increase somatic resources in trauma survivors to: 1) develop body awareness, 2) help clients become aware of sensations to use their body as an anchor to the present, 3) use body arousal as a gauge to pace the therapy process, and 4) access information provided by the client’s body and body memories. Another somatic technique was to develop dual awareness in the client to accept that the trauma occurred in the past while he or she was processing traumatic material in the present. If this dual awareness did not develop, it was easy for the client to experience hyper-arousal,
flashbacks, and retraumatization (Rothschild, 2000). In somatic trauma therapy, the first goal was to help the client learn to contain and reduce hyper-arousal. This skill was called “putting on the brakes” and was important when dealing with strong and possibly dangerous issues for the individual (Rothschild, 2003, p.19). When a client was unable to put on the brakes when working through trauma, hyper-arousal could quickly accelerate and lead to re-traumatization. Before the client learned to put on the breaks themselves, the therapist tried to keep the level of arousal low enough for therapy to be successful. Therapists using somatic trauma therapy helped clients recognize, slow down, and possibly stop this acceleration and feel that they were safe and in control. Feeling more in control often increased the willingness of traumatized clients to work through their traumatic memories. Rothschild (2003) emphasized that each individual had unique needs that should be evaluated to determine the course and pace of therapy.

Case studies of clients suffering from chronic musculoskeletal pain, who were treated with somatic psychotherapy, were presented by Bourque (2000). Both sufferers of chronic pain and survivors of traumatic experiences tended to show hypervigilance and difficulty experiencing pleasure or relaxing. During somatic psychotherapy the client was encouraged to accept messages from his or her body through physiological and psychological conditions. Often these conditions were expressed through somatic issues rather than through words and indicated underlying issues within a person, couple, family, or social system. A somatic method that allowed the body to speak, called the Dreambody process, used different sensory channels or modes. When this method was used with sufferers of chronic pain, they were asked to place their hand on the body area in pain and describe how it felt in that part of the body. If they were unable to describe
the sensations, the therapist asked them to either describe what they saw in that area or act out the image they saw. Using the body and mind together in an integrated manner allowed for a release of stored emotions. Somatic psychotherapy techniques used to integrate the body and mind were: 1) movement and touch with the environment to explore personal boundaries, 2) appropriate movement activities, and 3) relaxation and sometimes touch. It was important to use touch with caution and only with the client’s permission, especially when working with victims of sexual abuse who often suffer from chronic pain (Bourque, 2000).

2.8.5 Yoga

Michaelson (2005) proposed a model using yoga as an adjunctive treatment for women survivors of childhood sexual abuse. Michaelson’s rationale was that many symptoms resulting from childhood sexual abuse involved the body, but traditional methods of psychotherapy did not adequately incorporate the somatic experiences in the treatment process. Yoga, as a treatment method, focused on the client’s bodily experience of the abuse within the context of trauma treatment. Michaelson explained that yoga was effective to: 1) improve self-soothing abilities, 2) increase somatic awareness, 3) improve body image, and 4) strengthen interpersonal body boundaries. It was suggested that yoga should be introduced as a method in the treatment of childhood sexual abuse, to address somatic aspects of safety, integration, and reconnection. Clients should always be aware of how the yoga techniques are directly related to treating specific symptoms so that they can track their progress. The therapist and client can choose to use yoga at different times in the treatment process depending on the current focus. Yoga could be used to establish safety by aiding in affect modulation, safety in the
body, and healthy distraction from intrusive symptoms. As the client became more comfortable, yoga could be used to support both connect to the body in a safe and controlled way, and become more aware of body parts that were previously dissociated. The practice of yoga could help clients reconnect with their bodies by learning to enjoy it and feel powerful while present within it.

2.9 Literature on DMT with Children in General

Dance/movement therapy provides unique skills for working with children of all ages and with varying issues. It is beyond the scope of this research study to do a full review of all relevant literature on DMT with children. However, an overview is essential to illustrate DMT as an effective treatment method for the population of school-aged children who are sexually abused.

Dance/movement therapy is a unique method for working with infants and children who experience the world through their rapidly changing bodies. Children often learn about their world through bodily experiences, which establish emotional, social, physical, communicative, and cognitive development. These healthy bodily experiences also help children develop self-esteem, a dynamic body image, and appropriate body boundaries (Kestenberg & Buelte, as cited in Loman, 1998). Movement is the language used by children to communicate. Using movement is naturally enjoyable for children, and helps motivate them to learn and remember the skills taught in DMT (ADTA, 1999). The methods of DMT allow children to participate in meaningful explorations of the self, the environment, and others (Erfer & Ziv, 2006). In DMT “the body and movement are the vehicle for expression and communication in a pre-verbal and symbolic manner” (Payne, 1992, p. 42). Dance/movement therapy provides children with ways to express
thoughts and feelings through metaphors and symbols rather than with words (Payne, 1992). Although DMT is action-based, therapists do include verbalization and vocal exchanges. Since dance/movement therapists don’t rely solely on verbal language to communicate, DMT is useful for clients who have problems with their language skills. Dance/movement therapy is particularly helpful for children who have not developed language skills or are missing skills due to language, learning, or communication difficulties (Payne, 1992). Dance/movement therapists often use a set structure with children to ensure a predictable and secure environment and to help children feel safe enough to take more risks in their movement exploration and growth. Structure also helps support the development of a trusting relationship between the child and therapist (Erfer, 1995). The emphasis on nonverbal body-level communication in DMT confirms it as an ideal treatment method for normally developing infants and children, and those who struggle with various conditions (ADTA, 1999).

Dance/movement therapists who specialize in working with infants, children, and adolescents have a strong knowledge base in developmental and group theory and well-honed skills in non-verbal observation and movement behavior assessment. Dance/movement therapy can be beneficial for children who are involved in early intervention programs because the parents and other family members can easily be included in the treatment process to support the child and possibly improve the family’s functioning. In sessions with children, the DMT therapist meets them on a primary, non-verbal level by using movement observation and interactions. This process allows the children to create a positive and realistic self-image. When the therapist is able to join children in their symbolic movement world, they can help the children expand their
communication skills through using both verbal and non-verbal methods. Once this communication process occurs, the children have hopefully gained self-awareness, awareness of others, coping skills, and an improved ability to form relationships. In DMT, children learn to use motor patterns and movement dynamics that increase their flexibility and ability to adjust to many different situations (ADTA, 1999).

When working with children, their current developmental level is central to therapy and provides a framework for clinical assessment. Dance/movement therapy incorporates theories and techniques that are used to address developmental issues and deficits in children, that if not treated could cause future problems. Dance/movement therapists use the Kestenberg Movement Profile (KMP) (Kestenberg, 1975) that “outlines a predictable sequence of movement development that parallels psychological development” (Kestenberg Amighi, Loman, Lewis, & Sossin, 1999, p. 212). One part of the KMP sequence includes two phases: 1) pre-efforts, and 2) Efforts (Kestenberg, 1975). When a child first starts DMT, assessments are made by observing his or her use of: 1) spatial planes (area in space with two dimensions, side to side, up/down, forward/backward) 2) pre-efforts (immature patterns movements used and refined to develop more advanced patterns of movements), 3) Efforts (advanced patterns of movement that develop out of pre-efforts, and allow a person to interact with the environmental forces of space, gravity, and time), 4) Tension Flow rhythms and attributes (changes in muscle tension that create patterns and have certain qualities), 5) Shape Flow (spatial components of growing and shrinking that provide spatial aspects for tension flow), and 6) their body attitude (set movement qualities that can be easily observed such as alignment and style of movement). By detecting the presence or absence of these
aspects of development, the therapist determines the child’s developmental level and provides insight into any problems (Kestenberg Amighi et al., 1999). Studying an individual’s movements can also provide information about “early development, coping strategies, and personality configurations” and can “serve as a guide for a movement-based form of therapy and/or re-training” (Kestenberg Amighi et al., 1999, p. 2).

Through movement analysis as part of assessment, the therapist can gain information about physical and emotional experiences by the way an individual moves and holds themselves (Kestenberg Amighi et al., 1999). Based on all the information gathered, the dance/movement therapist then creates a treatment plan using specific interventions that will address each movement problem.

LeMessurier and Loman (2008) used specific case studies to demonstrate how DMT helped children get in touch with their bodies and speak through movement as part of a healing process to integrate all parts of the self. Although the case examples and some activities and concepts targeted children under 6 years of age, much of the material discussed DMT work with children in general. They approached therapy using the concept that clients knew what they needed to heal and if given a chance they would communicate what was important to them (Brooke, 2006). By using play and movement, children told their stories to find solutions and integrate their growth on all levels (Bromfield, 1994; Levy, 1995). LeMessurier and Loman discussed DMT techniques that helped children to: 1) build attachment, 2) increase self-regulation, 3) express unspoken emotions, 4) re-work unresolved developmental issues, and 5) heal from trauma and loss. A theoretical framework that combined developmental and relational approaches through DMT was also explained. Movement was a powerful and creative mode of healing that
helped children re-connect with their core self-tore-work problems non-verbally and build new pathways for healthy development. Interactions through movement promoted the learning of relationship skills and social regulation. Specifically, early traumatic memories that were held in the body could be addressed and healed through movement as a language that all ages could use and comprehend. Techniques such as attunement or reflecting muscle tension, rhythm, or body shape often were effective at building non-verbal empathy. Dance/movement therapists watched movement qualities of children and replicated the movement in their own bodies to attune to the children on a body level. Therapists found that young children were very responsive to this type of interaction and quickly engaged in relationships when they noticed someone connecting to them on a non-verbal level. These techniques also built trust in a relationship (Eberhard-Kaechele, as cited in LeMessurier & Loman, 2008), and validated feelings (Loman, 1998).

Dance/movement therapists continually helped clients progress through developmental phases and healthy growth (Loman, 1998). They created an environment that allowed children to explore movement dynamics, which stimulated joyful play and growth. Dance/movement therapists encouraged children to expand their movement repertoires to create more options for self-expression and problem solving. By matching the movement quality of a child, the dance/movement therapist could teach the child self-regulation. Children learned to regulate themselves and experience good feelings through non-verbal interactions with the therapist that modified their negative states and amplified positive states (LeMessurier & Loman, 2008). It was important to validate children’s feelings, increase their feeling recognition, and help them learn to identify feelings to enhance their emotional development. Being able to understand feelings and
non-verbal expressions was important for successful social interactions (Kornblum, 2002). Dance/movement therapists helped children learn to channel aggressive feelings into safe ways of expression that provided a release of negative impulses. Props such as scarves, parachutes, soft balls, hoops, and stretch cloths were often used with this population and were “neutral” objects because they let children express their mood and emotions in their own way.

Kornblum (2008) described her DMT approaches with a variety of children and presented case studies of both individual children and groups. Kornblum’s overall ideas and techniques for using DMT with children were: 1) using an open-ended structure, using what is present in the moment, 2) importance of meeting the child where her or she is at by the use of mirroring, matching movement qualities, and witnessing, 3) making the therapy space a safe container for strong feelings/building physical safe space, and respecting all feelings, 4) relevance of going from felt experience through movement to symbolic expression using verbalization, drawing, singing, and 5) using a developmental and observational framework to analyze and make goals, and using this information in therapy. Kornblum stated that children might not be ready to deal with deep psychological issues. Until they were ready to address old unhealthy behaviors, they could expand their movement repertoires, build on existing strengths, or develop new healthy ways of interacting. It was important for children to learn that strong feelings such as anger could give them important information about what they needed, and that feelings are “ok” if they learned a safe way to be angry. Children could learn to actively express all of their emotions and learned how to self-settle from feeling strong emotions. Since children were less articulate verbally, Kornblum found it helpful to use symbolism
to make verbal connections to movement experiences. The use of humor during therapy
to exaggerate body issues and movement helped children laugh at their own defenses or
patterns of interaction as a first step towards making change.

2.10 Current Literature on DMT with Victims of Trauma

In the past ten years there has been an increase in the literature and research that
addressed the use of DMT with child and adult victims of trauma. In all other sections of
this literature review, the focus was on treating traumatized children, particularly those
who were school aged. Due to the importance of DMT literature in development of the
DMT clinical model, all relevant literature on DMT with child and adult victims of
trauma in general as well as childhood sexual abuse was reviewed.

2.10.1 DMT with Trauma in General

Lumsden (2006) presented new developments in neuroscience and traumatology
research that provided support for DMT. Current research in traumatology identified two
types of trauma, simple and complex. Simple trauma was defined as a single traumatic
experience that most people had the resources to work through, while complex trauma
was defined as repeated traumatic experiences, often throughout life. Complex trauma
led to complex somatic, emotional, cognitive, and social symptoms. Since early
traumatizing experiences and relationships affected development of the emotional and
social brain, there was evidence that the brain could be stimulated later in development
by using certain conditions and activities. The complex nature of these issues required a
complex therapy, like DMT, that incorporated the body, emotional and aesthetic
expression, social interaction, and used symbols and metaphors (Lumsden, 2006).
Lumsden (2006) stated that dance and improvisational movement provided ways to work through trauma on two different levels, the poeitic and the cathartic. During the poeitic level there was a “playful, creative exploration of new modes of being, enabling growth of the self (and probably neurogenesis, the growth of nerve fibers and linking synapses) in a safe physical and social space” (Lumsden, 2006, p. 29). During the cathartic level the client could work thorough emotional trauma while being able to avoid freezing up or collapsing as a defense. Working through trauma on both the poeitic and cathartic level, allowed the therapist to help clients heal these aspects of the self to reduce the risk of re-traumatization during this process. Lumsden believed that recent progress in the fields of developmental neuroscience and traumatology provided new support for the value of DMT with traumatized individuals. Many aspects of the self that could be damaged by trauma early or later in life were the non-verbal aspects of a person and required the intervention of non-verbal stimulation. To work with non-verbal aspects of an individual, dance/movement therapists used the concepts of the body, the “embodied self”, and the affective self. In DMT, clients were encouraged to work on these non-verbal aspects through breathing, focusing, relaxation, and by using techniques to work with cross-linking right and left hemispheres of the brain (similar to EMDR). Until clients felt ready to address their trauma directly, they worked with abstract movement qualities without having to link them to a specific purpose, narrative, or relationship (Lumsden, 2006).

2.10.1.1 Children

Kornblum and Halsten (2006) discussed their therapy with traumatized children in general and provided specific information and case examples from their therapy groups.
They explained that it was critical to use the same space for every group session with this type of population. Their trauma groups were 60-90 minutes in duration, once a week throughout the school year in the school setting. Groups were closed and children were rarely added after the first few weeks of therapy to help develop trust within the group. Kornblum and Halsten suggested having co-therapists present due to the deep emotional material the children needed to work through and the need for one-on-one work when intense issues were triggered. Co-therapy also made it easier to deal with issues of countertransference. Having a predictable routine helped these children feel safe.

Sessions with set beginning and ending rituals centered and grounded the children. Their sessions had five sections: 1) opening ritual, 2) verbal/nonverbal check-in, 3) movement warm-up, 4) theme/creative movement story, and 5) snack and verbal processing. The goals for these groups included: 1) building a sense of empowerment, 2) increasing sense of safety and control, 3) increasing their ability to feel pleasure, 4) expanding the children’s movement repertoire and increasing self awareness, 5) improving their ability to modulate feelings, 6) increasing their ability to empathize with self and others, 7) developing group synchrony, 8) learning to link internal experiences to verbal expression, 9) increasing awareness of others, and 10) increasing their ability to self-soothe.

Kornblum and Halsten (2006) discussed the issues that presented during therapy and made suggestions for DMT with this population. They explained that often in the beginning of therapy children asked why they were in the group, and they seemed to think it was taboo to talk about abuse. The therapist could solicit answers to this question from the group to initiate collaborative relationships and lead toward the natural emergence of trauma themes. The children could also help create group rules for safety
and confidentiality. Another important way to address trust in therapy was to explicitly tell children that the therapist(s) could handle intense experiences and were not afraid of the children’s feelings (Friedrich, as cited in Kornblum & Halsten, 2006). The therapist demonstrated this trust non-verbally by matching the children’s intensity with movement and vocalizations to show they were not afraid. In every session, the check-in at the beginning was used as a time to discover pleasant commonalities between the children to balance the painful experiences that they also had in common. When the children realized that others had similar painful experiences, a bond was created that helped them begin to disclose material that could be anxiety-producing and caused over-arousal. In the warm-up section of therapy, children learned to connect and be aware of their bodies, learn new skills, make behavioral choices, release tension and anxiety, connect with others, strengthen boundaries, and learn to use strength and assertion safely. In general when traumatized children become fragmented, disorganized, and distracted, it was helpful for them to move around to music with a strong beat that helped organize them and make them feel settled and cohesive with the group. When a child felt too overwhelmed to verbalize, non-verbal expression was encouraged; in some cases other group members were given permission to mirror the child to communicate understanding and acceptance.

Various activities were suggested by Kornblum and Halsten (2006) to help traumatized children gain important skills, have positive interactions with others, and work through their trauma. For example, activities using a stretch cloth provided nurturing and pleasurable stimulation and help reaffirm and settle body boundaries. When children pulled each other on the cloth, touching the floor with their bodies
provided stimulation. This activity also required teamwork that developed trust and connection. In addition, meditation was done under a stretch cloth to create a sense of calm readiness and preparation for inner exploration. The cloth gave impulsive children something to hold on to, and provided a self-soothing tool. A cloth provided a feeling of being held or touched without the actual physical contact that could overwhelm traumatized children. To work on impulsivity, children were instructed to sit on the floor (lowering center of gravity increases impulse control), and follow the therapist in rhythmic drumming on the floor. When they were in control, they could begin to drum on their bodies. Having children push against objects, such as a wall, helped them channel their energy, feel empowered, and in control. Use of Weight and Strength helped them feel grounded and connected to their bodies. Pushing with Sustainment (maintaining the same level of intensity in muscle use) helped them reduce impulsivity. Specific techniques used in DMT for anxiety included: 1) using movement to express feelings while disclosing trauma or as a response to disclosing, 2) slowing down the process of sharing to check in with how other group members were feeling and to remind them of the importance of confidentiality, 3) using relaxation and grounding techniques (abdominal breathing, rhythmic movement), and 4) developing movement-based therapeutic stories that can be used as a metaphor to help children work through intense feelings. Additional specific techniques and general treatment approaches used in DMT with this population were discussed in this book chapter.

LeMessurier and Loman’s (2008) also discussed using DMT to enhance communication and healing in young children. They presented specific case studies and DMT techniques from their practice with children who had experienced complex trauma.
In general, they described case material with children who were younger than school age. However, many of their techniques and other information were relevant to working with all children. Since traumatic memories were held in the body, they concluded children could be healed through the body using integrated movement and play. They recommended that DMT therapists working with this population should: 1) create a safe holding environment, 2) provide attunement on a body level, 3) follow the child’s lead in his or her play and creative expression, and 4) support self-regulation. In therapy, children were encouraged to explore themes, label experiences, and create life narratives. LeMessurier and Loman believed that when traumatized children were given the chance to build long-term therapeutic relationships, they were often able to work through more specific aspects of trauma through movement re-enactment and re-choreography (Lewis, as cited in LeMessurier & Loman, 2008). Dance and mirroring can help traumatized children re-choreograph early attachment issues and progress to a higher developmental level (Lewis, as cited in LeMessurier & Loman, 2008). Opportunities to move together with the therapist allowed for the development of attachment and bonding. They cautioned that in-depth work often doesn’t begin until the second year of treatment.

Harris (2002, 2007) used DMT to address the needs of adolescents affected by war and organized violence. Although Harris’s work did not involve school aged children, his approach to developing group cohesiveness and use of a community based program emphasized the role of a child’s environment in the healing process. Harris (2002) first created a community-based, preventative intervention program with a group of 13 to 25-year-old refugees from Africa who resettled in Philadelphia, Pennsylvania. The program was implemented with 2-hour workshops that provided an opportunity for
children to perform the dances and songs they had learned in Africa. In these unstructured workshops, Harris let the children organize dancing and drumming and teach him about their dances and culture. Harris explained that the children’s active role and improvisation fostered resilience through their empowerment and working together.

In a later study Harris (2007) conducted DMT groups for 16 weeks, facilitated by adult males, for adolescent orphans who served as soldiers in Sierra Leone and were involved in wartime atrocities. Harris combined western trauma treatment methods with rituals for success in helping these adolescents overcome their violent impulses and rediscover the joy of working together with others. Harris’s approach to group DMT therapy introduced important concepts for DMT groups with traumatized school aged children. Harris taught the adolescents kinesthetic empathy, a technique that allowed them to feel and understand another person’s experience on a body level as well as a verbal level. Through kinesthetic empathy, the adolescents developed a stronger sense of safety that helped them to engage in more trusting interactions with their peers and counselors. The DMT sessions consisted of openly improvisational dance to popular music of Sierra Leone combined with structured physical exercises to address a psychosocial objective. This intervention evolved into a public performance by the adolescents based on their roles as both victims and perpetrators in war.

2.10.1.2 Adults

MacDonald (2004) presented the use of DMT with a woman suffering from PTSD. She described therapy sessions, personal journals written by the client, and an interview between the client and her case manager. The client had a long history of physical, emotional, and sexual abuse by both her biological parents and her foster
parents. She had participated in a survivor therapy group previous to starting DMT. Despite this therapy experience, the woman had delayed physical development, constant shallow breathing, her posture was stiff posture and she held her chin high; indications that she did not remember her abuse on a physical level. In her journal, the client described the process of separation from her physical body and travel to a happy and safe place in her mind. MacDonald’s main goals of therapy with PTSD clients were to help them acknowledge their experiences without being re-traumatized, and modify and transform their experiences through narratives. MacDonald explained that PTSD included the inability to integrate upsetting experiences into the memory. Storytelling was used to help address this issue. In DMT, MacDonald helped the woman create a safe place that would provide security as she told her story. The woman was given breaks from telling stories to work on body level issues. Therapeutic structures included: 1) naming and affirming parts of the body, 2) becoming aware of body parts that had become numb, and 3) breathing into all parts of the body. When troubling or distressing sensations arose, MacDonald helped her relate these sensations to her story and put them in context. One specific therapeutic structure that evolved out of DMT with this client was the creation of a timeline with representation of specific traumatic events in her childhood. For this client, this timeline was a diagonal pathway across the room, and she choreographed her story as she moved along the pathway. MacDonald explained retraumatization can occur when a client with PTSD begins to re-experience traumatic experiences on a physical and emotional level Retraumatization was avoided by keeping “all conscious physical activity firmly placed and attributed to the here and now or contained and identified as past events that have been survived and left behind”
MacDonald believed that full healing through movement occurred only when the client confronted painful experiences rather than simply enjoying the positive benefits inherent in movement. All movement experiences in therapy needed to be integrated and certain movement pieces needed to be worked through more than once before clients combined everything into their movement story. Although verbal narratives were important, unless traumatic experiences were integrated on a conscious level and felt by the body, they stayed in the body in unconscious and unhealthy ways. The creative process in DMT allowed for physicality, symbolism, and metaphor within a structured format where the body was used as a tool for expression.

Moore (2006) conducted DMT with adult victims of domestic violence as part of a university research project to study four different methods for treating this population. The main objective for each method was to study its psychotherapeutic efficacy with traumatized individuals. Participants included women, children, and adolescents (males only through age 19) with no restrictions on age, ethnicity, religion, or number or severity of trauma incidents. The DMT sessions began with 27 participants and 16 participants completed all sessions. Some findings were relevant to the treatment of sexually abused children and adult survivors of childhood sexual abuse because the domestic violence included body-level trauma. In addition some participants also had experienced sexual abuse or sexual violence at some point in their lives. In Moore’s study, questionnaires and movement analyses using Laban Movement Analysis (LMA), and the Kestenberg Movement Profile (KMP), were completed both pre and post therapy. In addition the Beck Depression Inventory (BDI) and the Brief Symptom Inventory (BSI) were completed for all adult and adolescent clients both pre and post therapy. The differences
between pre and post test BDI and BSI scores were statistically significant. Clients that completed therapy showed significant improvements in pain and stress reduction, had lower levels of depression, and used less medication. In addition, they developed a more positive body image and had increased self-awareness and self-confidence. Moore concluded that the body-mind format of DMT had a positive influence on the effects of abuse because it helped clients become aware of the “trauma-inherent fragmentation of body sensations and cognitions, and to find ways of non-threatening integration” (Moore, 2006, p. 114). According to Moore, dance/movement therapy successfully treated psychosomatic syndromes, fragmented body awareness, and body image; issues that were often not addressed in other therapy methods.

Gray (2001) described the use of DMT in a case study with a woman who survived torture. Although this work was not specifically victims of childhood sexual abuse, Gray presented information on how DMT could be used to treat body level symptoms that arose from trauma. Gray used various interventions to help her client reintegrate physically, emotionally, cognitively, and spiritually and helped the client understand the impact of her past experiences. Gray concluded that DMT could help survivors of torture rebuild their sense of wholeness and self, improve their interactions skills, and increase their ability to form relationships. This study supported earlier findings of Callaghan (1991) that torture effected people on both body and psychological levels. Memories of torture were encapsulated in the survivor’s body and appeared as physical symptoms.

Gray (2001) summarized the use of various DMT techniques to address negative affects of torture on the body such as: 1) high bodily tension (North, as cited in Gray,
problems with physical alignment due to muscular tension (Bernstein, as cited in Gray, 2001), 3) lack of movement skills that were learned early on in development (Aposhyan, as cited in Gray, 2001), and 3) constricted breathing, body image issues, and restricted use of their kinesphere (Gray, 2001). Gray cited Callaghan (1993) in a caution to dance/movement therapists that working with the body can stimulate memories more quickly than when using words. Since the body was directly involved in torture, therapists needed to be careful that their clients did not get overwhelmed. Dance/movement therapists used props such as balls, stretch bands, and scarves to break down the therapy process into smaller steps and created a better pace for recovery. The therapists worked with clients to help them overcome breathing patterns they developed to protect themselves by helping them feel and expand breathing and reduce their tendency to either hold their breath, breathe shallowly or breathe rapidly. Gray again cautioned that when helping clients expand their breath, therapists should not overwhelm their clients by introducing uncomfortable sensations too quickly. Gray stated it was difficult to decide about using touch in therapy with clients of this population or clients from a culture with different rules about touch. Gray found that using touch to create the sensation of pressure helped one client make connections to the resources present in his or her own body. In addition the use of touch helped them make full movement sequences instead of fragmented movements. Gray stated that because DMT focused on the body and movement in relation to psychological processes, it was a particularly good method for treating victims of torture. Gray (2001) clearly described that the work of the dance movement therapist is to “see what the body reveals, and what the client may want
to hide, and to gently and respectfully nurture the awareness in the client that his or her body is home, a relatively safe place to which to return” (p. 35).

Holloway (2006) conducted a literature based, Master’s research study to identify effective techniques in DMT and other fields of therapy that supported safety and containment during therapy with trauma survivors. Although this research focused on survivors of trauma in general, the methods were relevant to work with sexually abused children and adult survivors of sexual abuse. Holloway referenced literature that described methods to provide safety and containment when working with adult survivors of sexual abuse (Ambra, 1995; Frank, 1997) and abused children (Goodill, 1987). Holloway explained that DMT therapists needed various skills to support safety and containment. The body-based nature of DMT could bypass body-based defenses, lead to an overwhelming experience of emotions and re-traumatize the client. The methods presented to contain or ground the client during DMT included: 1) use the therapy room as a container (Gray, 2001), 2) control the impact of traumatic images by creating “mental tools” such as bricks or magic wands to protect (Ambra, 1995), 3) ground their bodies through the breath, connect their feet to the ground, using weight, and push and pull exercises (Ambra, 1995), 4) provide physical safety through the experience of different boundaries such as kinesphere boundaries (Ambra, 1995), 5) improve ego strength, encourage use of weight effort and vertical plane, establish a safe environment, use structure in sessions (Goodill, 1987), and 6) ground the client before ending each session, use techniques to create body awareness with breath, touch the ground, imagine and build a safe place, find safe distances and listen to the body, use self-assertion, and use the body as a container for feelings (Frank, 1997).
2.10.2 DMT with Childhood Sexual Abuse Victims

2.10.2.1 Children

Dance/movement therapists have continued to integrate techniques developed by Goodill (1987) and Weltman (1986) during their work with sexually abused children. Since the 1980’s, most literature on DMT with sexually abused individuals focused on work with adult survivors rather than children. However, there is an important study of a 5-year-old girl who disclosed her sexual abuse during the course of DMT (Ben-Asher & Koren, 2002). Ben-Asher and Koren (2002) detailed DMT techniques used before and after the abuse was disclosed, and included descriptions of the therapist’s somatic transference and countertransference experiences during the child’s therapy. In therapy the child displayed extreme and dangerous physical activity, the desire to undress and point out intimate body organs, a high level of arousal, and a lack of calmness; behaviors that were indicative of sexual abuse trauma. The ability of the therapist to detect transference and countertransference processes in her own body, in reaction to observing this behavior in the client, allowed her to understand the location of the young client’s primary traumatic memory cohesion and initiate the process of healing and recovery from the trauma (Ben-Asher & Koren, 2002). Shahar-Levy (as cited in Ben-Asher & Koren, 2002) defined primary traumatic memory cohesions as set combinations of physiological reactions, such as muscle contractions, that occur over time in response to trauma or reminders of previous trauma. Such cohesions are stored as body memories without cognitive awareness.

For her doctoral research, Truppi (2001) investigated the effects of DMT with sexually abused adolescent girls living in a residential treatment facility. She described
how movement could: 1) mend the split between the body and mind, 2) help an
individual re-connect with their body, and 3) create positive and pleasant associations to
replace painful memories. Truppi proposed that DMT allowed clients to first experience
feelings on a kinesthetic level and then on a logical, cognitive, level through verbal
processing. Truppi compared the effects of DMT versus a multi-model form of verbal
therapy (MVT) on the symptoms of self-concept, shame, and trauma in these sexually
abused adolescent girls. The results did not indicate a significant difference in the effects
of DMT as compared to MVT. However, Truppi suggested that the results could support
the following conclusions: 1) both interventions increased self-concept, 2) both decreased
shame but DMT was more effective than MVT, 3) MVT decreased dissociation slightly
more than DMT but both methods were successful, 4) both decreased sexual concern but
MVT was more effective, and 5) both were equally effective in reducing posttraumatic
stress symptoms (Truppi, 2001).

Kornblum (2008) presented general guidelines for DMT with children in her book
chapter titled *Dance/movement therapy with children*. She stressed the importance of
confidentiality when working with children. She stated children should be told that any
time during the course of therapy if the therapist thinks they are in danger they may need
to talk to other trusted adults. In this chapter Kornblum discussed a DMT group session
with 5 to 7-year-old boys who had experienced physical or sexual violence. Kornblum
described how creating a safe therapeutic container helped the children feel safe,
experience having their boundaries respected, and gain trust in the therapist and the
therapy process. The therapist had the children use props to build a physical, safe place
in the therapy room. An activity that used the safe spaces was to have everyone visit
each other’s place and ask permission before entering to insure that each child felt empowered and safe. As another non-verbal way of communicating, each child was asked to also make a drawing of a safe place. In following sessions, the children could go to a safe place in the room if needed. This work to create safe spaces showed the boys that the therapy room was a safe place for them and allowed them to reestablish trust and feel comfortable expressing their feelings.

D’Abate (2000) conducted a Master’s research study to investigate how combining DMT with Barrett’s Stages and Levels of Treatment model would effect treatment for abused and neglected children. By incorporating DMT interventions with Barrett’s model an approach was created that combined a more traditional treatment method with new forms of assessment and intervention based on movement, to promote healing and changes in the body. Barrett’s model had three stages and three levels within each stage: 1) create a context for change, 2) challenge patterns and expanding realities, and 3) consolidate information learned and address future issues. The synthesis of these two forms of treatment was called Moving Systems Therapy (MST). Moving Systems Therapy was process oriented, body-based, and used a staged format to change children and family’s dysfunctional patterns. The results indicated that MST supported greater improvements for abused and neglected children in therapy. Healing and transformation that helped a person directly experience their life, become fully sequenced, and release energy of past trauma occurred when: 1) the body, 2) the systems within the body, and 3) the system the body existed within changed. D’Abate explained that usually families and children that experienced trauma continued to use dysfunctional patterns and the systems they live in also needed to move in the direction of recovery and change. Moving
Systems Therapy helped traumatized children experience a stronger sense of safety and awareness in their bodies and in the world around them and supported their ability to change. It also provided workable realities and concrete challenges to children’s patterns to fit with their individual development and level of understanding.

Holecek (2000) conducted a Master’s research study to create a coding sheet to assess the movement characteristics of children to detect indicators of sexual abuse. In this study, Holecek ran 12 weekly DMT group sessions for 15 boys (10 with a history of sexual abuse), ages 7-12. Group A included juvenile sex offenders in residential treatment, and group B included boys who were referred to school at the residential treatment center due to their emotional and behavior issues. The goals for DMT sessions targeted issues that were present in all of the boys but not specific to sexual abuse issues. The goals for the boys were to: 1) identify and understand feelings, 2) explore choices that allow manifestation of feelings in a positive way, and 3) recognize consequences. Holecek observed and compared the movement characteristics of all 15 boys in three settings; the classroom, individual meetings, and DMT sessions. Holecek observed that boys who were sexually abused displayed the following movement characteristics: 1) quickness, 2) awake state, 3) hollowing and narrowing shape flow, 4) vertical spatial stress, 5) a tight holding of the torso, 6) using only distal body parts, 7) shallow breathing, and 8) no self touch as if they were not aware of their own bodies.

2.10.2.2 Adult Survivors.

In reviewing literature on DMT with adult survivors of sexual abuse, it became clear that many problems they encountered as adults are directly related to their childhood sexual abuse experiences. Articles are included that demonstrate both these
effects and effective treatment for adult survivors. The presence of problems that had extended for decades underscores the importance of treating sexually abused children as soon as possible to avoid problems later in life.

In a book chapter titled *The Use of the Creative Therapies with Sexual Abuse Survivors*, Valentine (2007) described the ultimate goal of DMT with women survivors of sexual abuse as a renewal of sensate connection and acceptance of their bodies. Valentine presented her perspective and a model of treatment for these women as a means for them to: 1) move toward a connection/reconnection with their bodies, 2) seek compassion and nourishment of the body-self, 3) find some pleasure and ease in moving, 4) appreciate their creativity in movement, 5) take in perceptions through the senses, 6) expand their movement repertoire to provide more options for coping with trauma issues, 7) discover preferred movement patterns, qualities, and other defining characteristics of the self, 8) gain a sense of control over hyper-arousal, and 9) integrate physical, emotional, and cognitive expression, particularly relating to the trauma and abuse from the past. Valentine suggested that a DMT approach with survivors of sexual abuse was very different than with other populations. The movement could cause them to recall the danger of being noticed by the perpetrator and triggered interior sensations with flashbacks and very painful feelings (Valentine, 2007). When starting DMT with adult individuals it was important to ease them into the process, and monitor their reactions. She suggested that clients needed to develop coping strategies for unexpected responses that might arise in the DMT process. The coping skills were often taught in individual therapy prior to group therapy. Accessing creativity was the beginning step to build self-esteem and empowerment that led to change. Valentine presented the following
guidelines for individual and group DMT sessions with this population: 1) let clients have control and choice over their participation, 2) form themes for the session based on issues expressed either verbally or through movement by the clients, 3) use the issues experienced by clients to help sequence interventions, 4) set boundaries of space and time, 5) encourage non-judgmental attitudes towards the body and movement, 6) respect defenses, and 7) provide safety and containment. Valentine suggested that co-therapy provided help with observation, individual work when required, and processing material and countertransferences after the sessions. Valentine based her group therapy on the qualities of healing present in group DMT as identified by Schmais (as cited in Valentine, 2007). Valentine explained that group DMT sessions were very empowering and provided cohesion, vitalization, and education that brought out repressed feelings in an environment of acceptance. Moving as a group facilitated expression where simple movements could metaphorically make powerful emotional statements. Finally, movement within a group, in the same rhythm and same spatial configuration, stimulated clients to identify with others and led to a common expression and a sense of solidarity (Schmais, as cited in Valentine, 2007). Clients could choose to use props with their movements, such as scarves and paper streamers that allowed them to focus on an external object, move into space outside of their bodies instead of focusing on internal sensations and feelings. Dance/movement therapy empowered these women to relive traumatic experiences and use sensory input to stay connected to present and be in charge and protect themselves instead of freezing and becoming passive. When a client had a flashback the dance/movement therapist helped them to quickly become more grounded by pushing on the wall or pushing into the ground with her feet (Valentine, 2007).
Frank (1997) documented a year-long course of DMT for an adult man who was
anally raped by a stranger when he was 12-years-old. At the time of DMT, the client was
31-years-old and suffered from a variety of issues such as panic attacks, depression,
inability to be touched by others, and a disturbed self-concept. After being in verbal
therapy for two years, his experience of being raped emerged and he was referred for
DMT. The DMT goals developed for the client were to: 1) feel safe (self-confidence and
 trusting others), 2) set limits, 3) accept and re-order his body image, 4) express his
 feelings, 5) self assertion, 6) make social and physical contact with other people, and 7)
 address his intimacy and sexuality issues. The client’s DMT was completed in four
stages: feeling safe, fighting, intimacy and parting stages. Each individual session had
four parts: 1) a verbal check in to see how the client was feeling and answer any
questions or concerns from the last session, 2) 30 minutes of non-verbal dance and
movement exercises, 3) a verbal discussion of feelings that arose during the movement
portion, and 4) a closing with a meditation that included breathing, grounding, and
reflection of the session. In the first (feeling) stage, Frank worked to build safety and
self-confidence, develop a trusting therapeutic relationship, and learn about the client.
The second (fighting) stage included touching exercises, exercises in balancing and
pushing away, using props such as balls and pillows to release aggression or express
aggression at abuser, using imagery and metaphors, and moving in different ways using
different body parts. In the third (intimacy) stage, Frank had the client trace his own
silhouette with chalk on floor, then color parts of his body that he felt were strong,
disliked, shameful, or that made him feel proud. Touching exercises were started in the
second stage and increased in the third stage to placing objects on the client’s body as he
lay on his stomach. Eventually the therapist could touch the client with his hands. In the fourth (parting) stage, Frank asked the client to state the last issues he would like to address and made a final evaluation of the client’s progress (Frank, 1997).

Mills and Daniluk (2002) conducted a qualitative, phenomenological study to document the DMT experience for five women who were sexually abused in childhood. This study emphasized the effects of sexual abuse and how the women had felt as children expressed in their own words. The researchers used unstructured, in-depth interviews to allow participants to reflect on their experiences in DMT and present their beliefs about the role these experiences played in their psychological healing. The analysis of the interviews detailed six general themes of their experience: 1) sense of spontaneity, 2) permission to play, 3) struggle, 4) freedom, 5) intimate connection, and 6) bodily reconnection. In terms of bodily reconnection, all of the participants felt that DMT involved a process of getting back into their bodies after feeling disconnected. This reconnection made them more comfortable with their range of bodily sensations, helped them feel safe and in control of these sensations, and ultimately reduced their need to distance or dissociate from their bodies. The women expressed surprise that play was encouraged in DMT. They enjoyed the therapy, rather than being upset, and were able to recapture the feelings of a carefree and joyful youth that the abuse had denied them. When the women talked about a sense of spontaneity, they described how they learned to move in a way that was free, self-determined, natural, and uncontrived. Initially, they had to overcome obstacles to spontaneous movement such as concentrating on others while they were moving and feeling self-conscious about their movements. After being in DMT for a longer time, the women began to focus more internally and expressed
themselves authentically through movement. The women also said DMT helped them realize that they didn’t have to mentally control everything they did. In fact, they could actually move without thinking first, which helped them become more connected to their bodies. Although it was difficult for them to deal with painful memories and experiences that were evoked in DMT, they continued DMT because they felt safe in this therapy environment and were learning the importance of working through painful memories in therapy. The emotional release, provided by DMT, allowed discharge of the physical energy that went with strong emotions. This discharge helped to deepen the healing process and create a sense of resolution (Mills & Daniluk, 2002).

Punger (2000), for Master’s thesis research, analyzed literature on dance/movement therapy from a body-self approach, and created a theoretical construct called “body-self dance/movement therapy”. The construct was applied to adult survivors of sexual abuse through a treatment model called “trauma-response body-self dance/movement therapy”. The construct was a combination of the theory and process of DMT with body-self theory that was developmentally based and used the body in movement and creativity to integrate the physical, emotional, and cognitive parts of the self (Punger, 2000). Following the literature review, Punger concluded that the symptoms, symptom formation, and treatment needs of adult survivors were all extremely body-sensitive because the violation occurred on the body level during childhood development. A further comparison of the treatment goals of survivors and the treatment goals of this construct provided strong support for the efficacy of using the model when treating survivors of childhood sexual abuse. The author used clinical vignettes to illustrate how the model was implemented that included: 1) helping them to
metaphorically contain the parts of their bodies that were fragmented or incomplete, 2) teaching them how to protect and defend themselves to avoid exposing their bodies to the risk of emotional decompensation, 3) using merging and empathetic connections to allow the client to take on some of the therapist’s ego strength and self-esteem, and 4) providing opportunities to explore their bodies through movement, and become aware of sensations and physical boundaries to reawaken parts of their bodies that were isolated or made numb from the abuse. Punger explained that exploration occurred on both physical and emotional level and that dance/movement therapists encouraged clients to experience feelings as they moved to connect the physical and emotional parts. At first when it was too difficult to express thoughts and feelings verbally, DMT provided non-verbal modes of expression. Through the process of realization clients developed a new understanding of their body and no longer blamed their body for the abuse. Once the clients had a more healthy relationship with their body they began to create healthy relationships with others. Dance/movement therapists helped in the process by teaching the concepts of interpersonal boundaries (Punger, 2000).

Meekums (1999), a dance/movement therapist, wrote an article presenting a model for recovery that she created for women who were sexually abused as children. The model emerged during earlier research on the experiences of 14 women involved in a set of 20 sessions of closed therapy groups that included qualitative, participatory, and reflexive methodology. The sessions involved different creative arts therapies and verbal interventions. Most of the data were collected using semi-structured interviews with each participant, approximately 2 months after she had completed all therapy sessions. The interviews were first coded, then the findings were discussed with all participants to get
their comments, and finally the interviews were recoded for use in a model for recovery.

Meekums described how the results of this study revealed that a certain level of perceived safety, that can be created using a variety of methods, must be reached for each person to ensure that interventions are not harmful. The most commonly referenced aspect of recovery in all of the interviews was the need for safety throughout the therapy process. Other important aspects of treatment that were incorporated into the model for recovery were: 1) witnessing others and being witnessed created a sense of universality and being understood, 2) working through the dilemma of finding embodiment was important to reclaim their body but could be re-traumatizing, 3) using the creative process as a way to unearth unconscious material, present and face this material as an image or feeling, and speak about it, 4) gaining a new perspective of themselves, and 5) laying the abuse to rest and gaining distance from these memories to move on in their life. Meekums emphasized that creative art therapies do not always work for all clients as some people prefer verbal methods. Any creative art therapies that are used with sexually abused clients should be used by well trained therapists to avoid problems.

Meekums (2000) wrote a book titled *Creative group therapy for women survivors of child sexual abuse Speaking the unspeakable* that described creative arts therapy overall, provided information concerning effects and prevalence of child sexual abuse, and detailed how creative arts therapies can be successful in treating women survivors of childhood sexual abuse. Meekums described three phases of art therapy: beginning, middle, and final phases. She described specific therapeutic activities to address the goals for each phase that used dance, art, music, or drama modalities.
CHAPTER 3: METHODOLOGY

3.1 Design

This was a literature based, comparative review of recent and foundational literature on the effects of childhood trauma, particularly sexual abuse, and treatment methods for these victims. The analysis of this literature provided data for creating a DMT clinical model for treating school aged children who were victims of sexual abuse. The Matrix Method was used to organize, reduce, and summarize a great volume of information, distributed in many resources. This method also allowed summarization of pertinent, single sources that contained extensive information and were difficult to organize (Garrard, 2004). A qualitative data analysis of the matrices provided a synthesis of the effects and treatment of childhood trauma, and ensured incorporation of all relevant literature into the DMT clinical model. The derived model has a strong foundation in past therapy and research and incorporates current understandings about trauma, sexual abuse, and current treatment approaches.

3.2 Subjects

There were no human subjects used for this study.

3.3 Procedures of Data Collection

The first step of analysis was the collection of theoretical, practical, and research literature concerning the effects of sexual abuse trauma in school aged children, ages 6-11, and subsequent treatment of this population. Literature on the effects and treatment of any trauma in children was also reviewed as it frequently encompassed child sexual abuse. The literature review was focused on the past ten years, 1997-2008. Foundational sources were also reviewed to provide the context for recent developments in the field.
The review of DMT literature was more extensive and included foundational and recent literature on DMT with children in general, and DMT with child victims of trauma and sexual abuse. A decision was made to include DMT literature on adult survivors of sexual abuse and other traumas to assure integration of all relevant DMT methods in the clinical model created as the outcome of this study.

Literature sources were collected using the following search words: dance therapy, movement therapy, sexual abuse, trauma, school aged children, treatment methods (including names of specific therapy models), and combinations of keywords. Main sources for the initial search were found using the PsychInfo database, the Drexel University library, and the American Dance Therapy website and listserv. Resources were also identified using the ancestry method for references used by authors of relevant documents (Mertens, 2005). Articles were reviewed from key journals such as *American Journal of Dance Therapy*, *The Arts in Psychotherapy*, *Child Abuse and Neglect*, *Psychotherapy*, and *Child Maltreatment*, in addition to other relevant journals, books and book chapters, Master’s theses, and Doctoral dissertations. The use of online databases provided a rapid and systematic search of extensive and recent resources and current information on the prevalence of sexual abuse in children.

Initially, literature sources were collected, read, copied and relevant information was abstracted into a general review matrix (Garrard, 2004). Documents gathered for this study were either photocopied and placed in 3-ring binders in chronological order or saved on the computer in labeled files. The review matrix was organized into rows for the literature sources and column topic areas of: Author/year, title, type of literature/year, title, type of study, theoretical orientation, and purpose/major conclusions. Literature that
specifically addressed DMT was kept separate in the review matrix because one goal of this research study was to compare DMT with other fields of therapy during creation of the DMT clinical model.

On completion of the comprehensive literature review and creation of the general review matrix, the second step was examination of the matrix data to determine similarities, differences, categories, and weaknesses or gaps in the data (Mertens, 2005). The data were reorganization into additional review matrices that reflected the main themes and objectives of the study (Garrard, 2004).

3.4 Operational Definition of Terms

The following terms were significant to understanding the information used and analyzed in this study. Some terms did not have a single agreed upon definition. To ensure consistency in this study the terms are defined as stated below:

- **Trauma** - Trauma was defined in the DSM-IV-TR as direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA, DSM-IV-TR, 2000, p. 463)

- **Sexual abuse** - The definition given by the National Association of Counsel for Children that was used for this study is “involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend and to which they are unable to give informed consent” (National Association of Counsel for Children, nd).
• **School aged children**- For the purposes of this study; the age range of 6-11 years was used to define school aged children (Hutchison, 2005). This age range, sometimes referred to as the latency stage, was a stage of psychosexual development originally devised by Sigmund Freud (Newman & Newman, 2006). In this research study the term latency was not used due to its’ specific connection to psychoanalysis.

• **Posttraumatic Stress Disorder (PTSD)** - PTSD was defined in the DSM-IV-TR as a set of typical symptoms that arose after a person had seen, experienced, or heard about a traumatic event. A person with this disorder reacted to the traumatic event by experiencing intense fear, helplessness and horror. Children also showed agitated or disorganized behavior. Symptoms commonly seen in clients included: repeatedly re-experiencing the traumatic event; persistent, increased, arousal; avoidance of stimuli associated with the traumatic event; and numbing of responsiveness. These symptoms must last for more than a month and must significantly affect the individual’s life (APA, DSM-IV-TR, 2000).

• **Dissociation**- Dissociation was cited as a symptom observed in victims of sexual abuse and was defined for this study as an “unconscious defense mechanism involving the segregation of any group of mental or behavioral processes from the rest of the person’s psychic activity” (Kaplan & Sadock, 1998, p.660).

• **Embodiment**- Embodiment was defined for this study as the process of experiencing the self in and through the body (Young, 1992). A person had a sense of embodiment when he or she could feel that they were present mentally and physically in the moment (Aposhyan, 2004; Meekums, 2000).
• **Dance/movement therapy** - Dance/movement therapy was defined as the psychotherapeutic use of movement to help people expand their emotional, cognitive and physical integration (ADTA, nd). The main goal of DMT was to help clients integrate their mind, body, and emotions. Through this integration they find emotional growth and self-definition (Mills & Daniluk, 2002). A person with emotional and body integration could use his or her body to express emotional feelings (Hancock Center for Movement Arts and Therapies Inc., nd).

3.5 Qualitative Content Analysis of Data Matrices

The third step of this study was comparison of data in the matrices using the matrix method form of analysis (Mertens, 2005). Data were quantified and reviewed to determine the prominent concepts or categories of non-DMT therapies that would form the framework for comparison with the DMT concepts and methods. I used connecting and overlapping data on the effects of sexual abuse on children and their treatment needs, from the reviewed literature, to identify how unique qualities of DMT were used to treat this population.

3.6 Outcomes

The outcome of this study is an informed DMT clinical model, based on the identified effects and treatments within most fields of psychotherapy, to treat school aged children who were victims of sexual abuse. This model has a foundation in earlier DMT theory, practice, and research, and it incorporates new understandings and methods of DMT and other forms of therapy with this population. The model demonstrates the unique contribution that DMT can provide in the treatment of sexually abused children.
CHAPTER 4: RESULTS

4.1 Categorization of the Literature Review

To develop a clinical DMT treatment model, all theory, practice, and research literature from the past ten years was reviewed that specifically addressed the effects or treatment of childhood sexual abuse or childhood trauma in general as it often encompassed sexual abuse. For DMT, all literature on sexual abuse and other trauma in both children and adult survivors was reviewed. Foundational literature sources were included to provide a historic context for recent developments in each field. Initially, the review was limited to literature from the past ten years for all non-DMT modes of treatment for sexual abuse and other forms of trauma in children. Upon completing the review, it was apparent that there was a large volume of literature within the past ten years for some therapeutic approaches. In contrast, there were other therapeutic fields with very few key resources on this topic. Therefore in some areas, literature on adult survivors of childhood trauma or literature that was written before 1997 was also reviewed. This was done to provide a fuller description of certain therapeutic methods that appeared to be significant in the treatment of sexually abused and otherwise traumatized children.

4.2 Qualitative Analysis of the Review Matrix

4.2.1 Phase 1, Categorize Abstracted Literature into 4 Matrices

As the literature was reviewed, relevant information was abstracted into an extensive review matrix containing over 140 abstracted entries. Following qualitative analysis of this initial review matrix, the abstracted literature was categorized into four new review matrices: 1) effects in children who were victims of trauma in general or
sexual abuse specifically, 2) treatment concerns and overall guidelines for work with
sexually abused or otherwise traumatized children, 3) specific treatment models and
methods used with sexually abused or otherwise traumatized children, and 4) DMT
methods for treatment of sexually abused or otherwise traumatized children and treatment
of adult survivors of trauma including childhood sexual abuse (CSA). Due to differences
in the volume of literature within each review matrix, and the need for quantitative and
qualitative methods to describe the effects, guidelines and concerns, and treatment; a
slightly different approach was needed during some steps of the synthesis.

4.2.2 Phase 2, Review and Synthesis of Matrices 1-4

In the second phase of analysis, data in each of the four matrices were reviewed to
find any common concepts and record the frequency of occurrence for these concepts.

4.2.2.1 Matrix 1

Matrix 1 contained a synthesis of literature on the effects observed in child
victims of trauma in general or sexual abuse specifically that were considered important
to address in therapy (see Appendix A). The large numbers of effects in Matrix 1 were
tabulated by the number of times they occurred in the matrix literature. Any effect that
appeared at least three times in the matrix was included in a data set for the next step of
analysis. The frequency threshold of inclusion was set at 3 following a review of effects
from Matrix 1 data that clarified that this threshold would provide a synthesized and
inclusive list of effects. Without a frequency threshold of inclusion set, the vastness of
the data set would have precluded its use to create a DMT clinical model. Each effect
that occurred less than three times, but was described as significant in one or two
literature sources, was also reviewed to ensure that no important effects were overlooked.
or lost in the analysis. All important effects were incorporated during creation of the final treatment categories in phase 3 of the analysis (see Table 1).

4.2.2.2 Matrix 2

The data in Matrix 2 were general guidelines suggested for working with this population and some concerns presented by therapists who treated these children (see Appendix B). Literature in Matrix 2 was limited and it was more easily organized under two categories; guidelines and concerns. The guidelines for treatment synthesized from Matrix 2 were:

- Understand that the symptoms of traumatized children are complex with no single syndrome. Each child has to be assessed and treated on an individual basis. Complex and multi-model treatment methods may be needed to respect the integrity of the child.
- Non-offending caregivers are important to include in the treatment process either in the therapy sessions and/or outside therapy.
- During treatment, it is important to set boundaries and create structure to provide containment and support.
- Children’s abuse-specific attributions (attempting to make sense of why abuse occurred) are complicated. If abused children become aware of and reflect on their abuse-specific attributions they can reevaluate their assumptions and create healthier views of themselves and others.
- Develop a trusting therapeutic relationship to help counteract previous betrayal and give these children a chance to feel safe and secure.
- Provide a chance for traumatized children to tell their story and be witnessed and understood by someone they trust. Despite shameful and secret elements of their story, telling it helps them create a new story and a new perspective on their life.

The concerns that needed to be considered during treatment were synthesized from Matrix 2:

- Treatment providers need to be careful to not base conclusions about whether abuse has occurred solely on a child’s behavior. Even though sexualized play or other behaviors is observed, it isn’t always enough evidence. Conversely, even if suspicious behaviors are not observed, abuse shouldn’t be ruled out completely.
- Many uncertainties characterize this population. The optimal length of treatment is unknown as is whether asymptomatic children should be treated.
Table 1. *Effects of trauma and sexual abuse in children sorted by the number of times they were addressed in Matrix 1 (30 sources total)*

<table>
<thead>
<tr>
<th>Effect(s)</th>
<th># of key sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embodiment, body image, biological/medical/physical issues</td>
<td>12</td>
</tr>
<tr>
<td>Disassociative symptoms/DID</td>
<td>9</td>
</tr>
<tr>
<td>PTSD</td>
<td>8</td>
</tr>
<tr>
<td>Emotional problems</td>
<td>7</td>
</tr>
<tr>
<td>Issues in development of self/personal identity</td>
<td>7</td>
</tr>
<tr>
<td>Behavioral problems</td>
<td>7</td>
</tr>
<tr>
<td>Poor self-esteem</td>
<td>6</td>
</tr>
<tr>
<td>Sexual issues</td>
<td>6</td>
</tr>
<tr>
<td>Fear</td>
<td>6</td>
</tr>
<tr>
<td>Anxiety</td>
<td>5</td>
</tr>
<tr>
<td>Aggression/violence</td>
<td>5</td>
</tr>
<tr>
<td>Unhealthy attachment styles</td>
<td>5</td>
</tr>
<tr>
<td>Cognitive issues</td>
<td>5</td>
</tr>
<tr>
<td>Developmental problems</td>
<td>4</td>
</tr>
<tr>
<td>Guilt (self-blame)/Shame</td>
<td>4</td>
</tr>
<tr>
<td>Interpersonal issues</td>
<td>4</td>
</tr>
<tr>
<td>Anger</td>
<td>4</td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
</tr>
<tr>
<td>Academic problems</td>
<td>4</td>
</tr>
<tr>
<td>Damage to relationships</td>
<td>3</td>
</tr>
<tr>
<td>Drug and alcohol use</td>
<td>3</td>
</tr>
<tr>
<td>Social isolation</td>
<td>3</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>3</td>
</tr>
<tr>
<td>Sleep disturbances</td>
<td>3</td>
</tr>
<tr>
<td>Suicidal thoughts and attempts</td>
<td>3</td>
</tr>
</tbody>
</table>

- Abuse occurs as part of a larger environment with issues that occur outside of therapy that also need to be addressed to help the child, particularly victims of intra-familial sexual abuse.

- Forcing children to repeat their trauma story or asking the same questions repeatedly can reconnect them with painful memories, worsen their symptoms, and damage the therapeutic relationship.

- The person providing treatment intervention should not make promises that are not guaranteed. They must be open and honest with the child about what might happen once he or she discloses the abuse. They need to answer the child’s questions in terms of placement, perpetrator incarceration, and possible familial responses.
• It is essential that therapy is guided by the child’s needs, not by the therapist’s own interpretations of the child’s needs or what they think constitutes good therapy.

• Do not back off or discourage children from expressing their traumatic experiences once they have reached the point of being able to do it.

• Treatment of abuse and neglect is related to issues that are influenced by ethnic and religious beliefs that make treatment challenging, so therapists must take cultural information into consideration.

4.2.2.3 Matrix 3

Matrix 3 is a synthesis of specific treatment models and methods (excluding DMT) used in therapy with children who were sexually abused or otherwise traumatized (see Appendix C). Despite the different treatment methods used with sexually abused or otherwise traumatized children, there were also many similarities and overlapping themes in the models and methods. Therefore, similar to Matrix 1, specific treatment methods in Matrix 3 were tabulated by the number of times they occurred; those that occurred 3 or more times were included in the analysis. Also as in Matrix 1, methods that occurred less than three times were reviewed to make sure that no important methods would be overlooked or lost in the analysis process. A frequency threshold of inclusion was also set at 3, following a review of Matrix 3 data that clarified that this threshold would provide a synthesized and inclusive list of treatment data (see Table 2).

The data were next organized into preliminary treatment categories to represent the most often discussed concepts. The overall preliminary treatment categories were:

• Exposure techniques

• Include non-offending caregivers

• Education (psycho-education, sex education, teaching life skills)

• Addressing body level issues, focusing on the body
Table 2. *Quantified data on the treatment of traumatized and sexually abused children from Matrix 3 (49 sources total)*

<table>
<thead>
<tr>
<th>Treatment(s)</th>
<th># of key sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work on developing age appropriate behavior</td>
<td>11</td>
</tr>
<tr>
<td>Education/psycho-education/ sex education</td>
<td>10</td>
</tr>
<tr>
<td>Work on cognitive beliefs/restructuring/reframing, explore thoughts</td>
<td>9</td>
</tr>
<tr>
<td>Include non-offending caregivers</td>
<td>7</td>
</tr>
<tr>
<td>Use/address common themes</td>
<td>7</td>
</tr>
<tr>
<td>Teach coping skills (memories of abuse, guilt/anxiety)</td>
<td>7</td>
</tr>
<tr>
<td>Containment/boundaries: help improve sense of safety</td>
<td>6</td>
</tr>
<tr>
<td>Storytelling/fairytale</td>
<td>6</td>
</tr>
<tr>
<td>Breathing/relaxation</td>
<td>6</td>
</tr>
<tr>
<td>Teach parents skills (behavioral education, contract to increase compliance/reduce fear response)</td>
<td>5</td>
</tr>
<tr>
<td>Body safety skills/abuse response</td>
<td>5</td>
</tr>
<tr>
<td>Re-enact trauma</td>
<td>5</td>
</tr>
<tr>
<td>Non-verbal techniques</td>
<td>5</td>
</tr>
<tr>
<td>Gradual exposure</td>
<td>4</td>
</tr>
<tr>
<td>Tell trauma narrative (can combine with gradual exposure)</td>
<td>4</td>
</tr>
<tr>
<td>Work on non-verbal aspects of person/trauma</td>
<td>4</td>
</tr>
<tr>
<td>Create safe place/keep things familiar, minimize anxiety</td>
<td>4</td>
</tr>
<tr>
<td>Develop therapeutic relationship</td>
<td>4</td>
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<tr>
<td>Use of symbolic materials</td>
<td>4</td>
</tr>
<tr>
<td>Give clients control</td>
<td>4</td>
</tr>
<tr>
<td>Use symbolism metaphors</td>
<td>3</td>
</tr>
<tr>
<td>Unstructured therapy, Structured therapy</td>
<td>3</td>
</tr>
<tr>
<td>Complex therapy to deal with many aspects</td>
<td>3</td>
</tr>
<tr>
<td>Activities to provide distance between individual and trauma</td>
<td>3</td>
</tr>
<tr>
<td>Role playing (use props instead of people)</td>
<td>3</td>
</tr>
<tr>
<td>Communication and coping with emotions</td>
<td>3</td>
</tr>
<tr>
<td>Work on relationship/social skills</td>
<td>3</td>
</tr>
<tr>
<td>Problem solving skills</td>
<td>3</td>
</tr>
<tr>
<td>Processing memories/reminders of trauma</td>
<td>3</td>
</tr>
<tr>
<td>Activities that use left and right sides of brain</td>
<td>3</td>
</tr>
<tr>
<td>Explore emotions: express feelings, questions, fears</td>
<td>3</td>
</tr>
<tr>
<td>Use play to gain mastery over trauma experiences/growth method</td>
<td>3</td>
</tr>
<tr>
<td>Open or directed group discussions (especially understanding SA)</td>
<td>3</td>
</tr>
<tr>
<td>Improvisation</td>
<td>3</td>
</tr>
</tbody>
</table>
• Cognitive techniques
• Working on emotions and affect (expressing, regulation)
• Working on controlling anxiety, fear, and arousal
• Therapy environment and interactions
• Addressing issues in development and lack of certain skills
• Overall therapy structure recommendations
• Working through trauma

4.2.2.4 Matrix 4

Matrix 4 was a summary of the DMT methods used with children who were sexually abused or otherwise traumatized and adult survivors of childhood sexual abuse (see Appendix D). At this time, a decision was made to not include the DMT literature on adult victims of other forms of trauma in the analysis. The initial review revealed that the literature on trauma in adults, other than sexual abuse, appeared less directly related to the stated effects or treatment for sexual abuse in children. There were five subcategories of the literature, divided in Matrix 4 by the target age of the client and the type of trauma, to identify the population that each literature source was targeting. In addition, a column was created in Matrix 4 to note the specific age group of children or adults targeted in the literature. This organization of the literature sources clarified whether the theories and methods in the model were from work with school aged children or revised from work with other ages of children or adults. The treatment methods in Matrix 4 were summarized into nine concepts:

• Techniques to address the body level affects of trauma, body level interventions
• Safety and containment
• Attunement
• Guidelines and concerns
• Addressing issues in movement
• Integration and reintegration
• Expression of emotions and working through trauma experiences and memories
• Strengthening self esteem, sense of self, emphasizing the positives
• Impulsivity control

4.2.3 Phase 3, Analysis of Identified Categories and Concepts

In the third phase of analysis the identified categories and concepts from each of the four matrices were merged into a comprehensive and functional format, taking into account that categories were not mutually exclusive. During analysis in phase 1, it was noted that each treatment category in Matrix 3 directly addressed one or more effects in Matrix 1. To create the finalized treatment categories, the effects identified from the analysis of Matrix 1 data were placed in the appropriate categories from Matrix 3 that would best encompass that effect. Also some categories from Matrix 3 were adjusted to better address the important effects identified in Matrix 1. Finally, the treatment categories from Matrix 3 were chosen as the basic framework for addressing the effects, guidelines, and concerns in treating this population.

The majority of data on DMT treatment from Matrix 4 were not used to develop the final treatment categories to allow for comparison of DMT and non-DMT treatment methods and creation of the DMT clinical model. However, a few DMT sources that focused on assessment and observation of body level effects of sexual abuse in children, rather than treatment methods, were abstracted into Matrix 1 to gain a more
comprehensive understanding of the effects of sexual abuse on children. Since the analysis of Matrix 2 identified overall guidelines and concerns needed for treatment of sexually abused children in this model, they were not specifically addressed under every category to avoid redundancy. However, the guidelines and concerns from Matrix 2 were addressed overall in the treatment model. The eight final categories created from the concepts of Matrix 1 and 3 are listed below with the commonly identified effects from Matrix 1 that were incorporated into the categories (see Table 3) (see Appendix A for complete effects descriptions and sources).

4.2.4 Phase 4, Creation of a DMT Clinical Model

The final phase of the analysis was the creation of a DMT clinical model to be used with school aged children who were sexually abused. The analyzed data on DMT from Matrix 4 was compared to the eight treatment categories to evaluate DMT for traumatized and abused children relative to the methods used by non-DMT therapists over the past ten years. The comparison revealed that many DMT methods used with this population would address effects targeted by the treatment methods of non-DMT therapies. The similar effects addressed by DMT and non-DMT therapists included: 1) body level effects, 2) problems with emotional expression, 3) lack of a sense of control, safety, and containment, 4) inability to work through and integrate traumatic experiences, 5) lack of self-esteem, sense of self, identity, and 6) limited or damaged skills caused by negative experiences, such as social and developmental skills. Specific methods, and theories for their use varied greatly between DMT and the other forms of therapy. Some unique DMT methods included: 1) adjusting body attitude and expanding movement repertoire, 2) integration or reintegration of parts of the self, and 3) use of non-verbal
techniques, particularly attunement. Comparison of DMT methods with non-DMT methods led to the development of a clinical model that addressed a wide range of effects observed in sexually abused or traumatized children and treated using many forms of therapy. In addition, foundational DMT literature that was not included in Matrix 4 was also used to inform the development of this model. The discussion of the clinical model is presented in Chapter 5 in the following format: 1) General baseline considerations, 2) Rationale and assumptions, 3) Overall goals, 4) Clinical model description, 5) Guidelines for structuring therapy sessions, 6) Addressing the eight treatment categories, and 7) DMT clinical model.
Table 3. Final categories for the DMT clinical treatment model for sexually abused children and the effects from Matrix 1 that were addressed within each category

<table>
<thead>
<tr>
<th>Treatment category</th>
<th>Commonly identified effects</th>
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</table>
| **Treatment Category 1**: Sexual abuse is a negative experience that directly involves and damages a child’s body, physically and psychologically. Sexually abused children often develop body level issues such as dissociation, somatic issues, negative body image, and negative body/somatic memories. | • Dissociation  
• Problems with embodiment  
• Body memories/somatic memories  
• Development of negative body image  
• Biological/medical/physical issues  
• Somatic issues and Body/movement issues |
| **Treatment Category 2**: Sexually abused children have difficulty expressing their emotions. They may either be unable to control their emotions or have the need to over-control them. Their memories associated with abuse contain specific sensations, sounds, and images. If these sensations are triggered, they easily cause flight or fight reactions. | • Difficulty expressing emotions and the need to over-control their emotions  
• Affect regulation problems  
• Emotional memories |
| **Treatment Category 3**: Abusive, traumatizing experiences that children can not control can be terrifying, confusing, and painful. Abuse can cause strong feelings of fear and high levels of anxiety that make children susceptible to hyper-arousal or becoming overwhelmed physically and emotionally. These issues affect various aspects of a child’s life and create challenges for therapists working with them. | • Experience feeling of helplessness, powerless and out of control  
• Feelings of mistrust and hypervigilance  
• Experience fear in general as well as fear of further trauma/abuse  
• Anxiety issues  
• Learning difficulties, attention disorders  
• Posttraumatic Stress Disorder (PTSD)  
• Acute stress disorder  
• Hyper-arousal  
• Difficulty self-soothing |
| **Treatment Category 4**: Sexual abuse during childhood severely disrupts a child’s opportunities to engage in childlike activities. Children become so preoccupied with keeping safe that they miss chances to play and use their imagination to interact with the outside world. Sexually abused children are constantly trying to survive physically and psychologically. | • Issues related to play  
• Cognitive issues |
<table>
<thead>
<tr>
<th>Treatment category</th>
<th>Commonly identified effects</th>
</tr>
</thead>
</table>
| Treatment Category 5: Sexually abused children often lack certain developmental skills or have interruption and damage in their development. They may form unhealthy attachment patterns or not develop a secure sense of self or identity. | • Identity/sense of self  
• Attachment issues  
• Developmental issues |
| Treatment Category 6: Although sexual abuse is clearly the fault of the perpetrator, abused children often feel shameful and dirty about the experience. They feel guilty because they did not stop or disclose the abuse earlier. These feelings and negative cognitions damage self-esteem, and can lead to depression, and suicidal thoughts and behaviors. | • Self-concept  
• Unhealthy/maladaptive cognitions |
| Treatment Category 7: Sexually abused children often develop problems with relationships, social skills, and social interactions with other children and adults. They learn that they can not trust some adults. Abused children can develop age or socially inappropriate behaviors, for example precocious sexual behavior, that disrupts social interactions and leads to social isolation. | • Aggression/violence  
• Behavior issues  
• Social skills/interactions/relationships issues  
• Sexualized behavior  
• Lack of eye contact  
• Lack of direct interactions with others  
• Need to control space between self and others  
• Ambivalence between wanting to connect with others and feeling distrustful |
| Treatment Category 8: Abused children may strongly avoid remembering their painful and overwhelming experiences. Children may however, have intrusive thoughts, relive traumatic memories, or unconsciously reenact a traumatic incident physically. In therapy, these children commonly do not remember, or can not verbalize, their experiences. | • Anxiety and avoidance behavior |
CHAPTER 5: DISCUSSION

5.1 Important Findings from the Literature Review

Review of the literature for creating the clinical DMT model for this research study made it clear that the issues faced by victims of trauma and sexual abuse are complex with no single, identified syndrome. Any model and treatment method used must also be complex and use a multi-modal format. Despite the complexity and diversity of the numerous treatment methods, there are overall guidelines that are foundational for most treatment methods used to treat children who were victims of trauma or sexual abuse, including DMT. These foundational guidelines are: 1) develop a trusting therapeutic relationship, 2) create a safe contained environment for therapy sessions, 3) teach children coping skills to help them work through their experiences safely, 4) help children be in control of what they do in therapy by working on issues at a comfortable pace set by the child, 5) help the child work through the traumatic experiences so that he or she can become a healthier person who is not controlled by these experiences, and 6) provide structure, consistency, and confidentiality.

Some techniques used in non-DMT with this population, although they vary depending on the form of treatment, are very similar to the methods used in DMT. These techniques include breathing and relaxation techniques (Boyd Webb, 2006; Faust & Katchen, 2004; Ogden, Pain & Fisher, 2006), safety skills including body safety, feeling in control, and assertiveness (Heiman & Ettin, 2001; King et al., 2000; Ross & O’Carroll, 2004), techniques to help clients learn to recognize, explore, and express their thoughts and feelings (Ahmad & Sundelin-Wahlsten, 2008; Carbonell & Parteleno-Barehmi, 1999; Cohen, Deblinger, Mannarino & Steer, 2004), being aware of developmental concepts...
and improving developmental issues (Bannister, 2003; Chertoff, 1998), techniques to reenact traumatic experiences and express trauma narrative (Carbonell & Parteleno-Barehmi, 1999; Cohen, Mannarino & Deblinger, 2006; Steele, 2003), and techniques to help with anxiety, fear, and hyper-arousal (Chemtob et al., 2002; Grosz, Kempe & Kelly, 2000; Lovett, 2007; Ryan & Needham, 2001).

In comparing the foundational and recent DMT literature on treating victims of childhood sexual abuse, it appears that many of the goals and techniques are very similar. In both recent and foundational DMT with this population the goals generally are: 1) expand movement repertoire, 2) address issues of touch, 3) increase the client’s sense of control over his or her body, boundaries, impulses, and responses, 4) increase body awareness and body integrity, 5) expand creativity, 6) help express thoughts and feelings, 7) improve body image, and 8) empower the client. Common techniques in recent and foundational DMT include: 1) use of non-verbal expression, 2) use of strong rhythmic patterns to help ground and organize the client, 3) help the client re-enact abuse safely, 4) give the verbal and non-verbal message that it is ok to talk about the abuse, and 5) help address developmental issues and allow for the client to re-experience earlier stages of development. It is clear that recent DMT literature, as well as the recent literature from other fields on this topic, provide support for the foundational DMT literature through new research evidence, additional DMT case studies, and more experience and practice in DMT. All of these factors support the work of dance/movement therapists with child victims and adult survivors of sexual abuse, and other traumas. It appears that recent DMT work with victims of trauma or sexual abuse is very similar to the foundational work in the 1980’s rather than having found completely different ways of treating this
population. Over the past ten years DMT work in this area has added to what was done and understood in the past in DMT.

Despite literature that strongly supports the use of DMT to treat victims of sexual abuse and other traumas, there is a lack of literature that specifically focuses on use of DMT with school aged children. Most DMT literature describes treatment with children as a general group, sometimes including adolescents. Some DMT literature includes examples of individual cases or group therapy that involves school aged children, but the description of therapy goals and methods often doesn’t focus on how this age group was targeted. To make a DMT clinical model that was appropriate for school aged children specifically, each therapeutic structure and concept described in DMT literature was carefully reviewed. It was vital to select structures and concepts that corresponded with developmental stages of school aged children and addressed working with victims of trauma. Some information used in this model was adapted from DMT literature on treatment of adult survivors, adolescents, or very young children who were victims of sexual abuse. Non-DMT approaches used to treat school aged children who were victims of sexual abuse or other forms of trauma were summarized to create the eight treatment categories. This use of other psychotherapy concepts and treatment approaches provided an additional way to tailor the model for school aged children despite the lack of specific DMT literature on this age group.

Throughout the narrative description of the DMT clinical model, any adjustments in treatments made for school aged children are noted. This refinement of the model is complicated because traumatized children often are not functioning at their expected developmental level based on their age. They may have developmental delays,
disruptions, or appear socially or emotionally advanced because of unhealthy experiences. Due to anticipated developmental issues and limited information for DMT with school aged children, this model is designed to allow adjustments for a specific group of children. Once a client/group assessment is complete, the flexibility of the interventions, organizational structure, and time frame for this model allow the therapist to make the appropriate adjustments and create the best fit possible for their group.

5.1.1 DMT as a Unique Body-based Treatment Method

This literature review provides evidence that dance/movement therapy is a unique body based treatment with specialized techniques and theories to address the needs of sexually abused children. Dance/movement therapists observe their clients for unique body attitudes, movement qualities, and interactions on a non-verbal level. They are trained to identify specific body related issues in sexually abused and otherwise traumatized people that may not be recognized by other therapists. In DMT, the body is purposefully involved through specific techniques to help the client: 1) expand their movement repertoire, 2) experience kinesthetic attunement, 3) explore body level experiences and sensations, and 4) return to pre-verbal and other earlier stages of development where certain problems may have arisen. DMT involves specialized techniques, some come from the Kestenberg Movement Profile (KMP), that allow therapists to help children return to earlier stages of development to work through issues and experiences related to a particular stage. This process requires the almost exclusive use of movement as it can not be experienced or understood on a conscious level and is instead experienced unconsciously through the body and movement. Unlike many other forms of therapy, the emphasis in DMT on non-verbal methods as means for expression,
exploration, and connection to others creates safety and trust for sexually abused children who have difficulties expressing their traumatic experiences verbally. Creative use of non-verbal methods can help create distance between children and their traumatic experiences and allow them to address their experiences in a less direct way.

Since the 1980’s, there have been considerable improvements in identification of sexual abuse victims, increases in treatment styles and methods for this population, and increases in the number of people seeking therapy for sexual abuse. Specifically within DMT, recent literature detailing the use of DMT with victims of childhood sexual abuse has expanded the understanding of how this type of therapy is used to successfully treat this population. Recent research on the neurobiological effects of trauma, and possible clinical applications of this knowledge, provides considerable evidence in support of DMT as a preferred form of treatment (Kendall-Tackett, 2000; Perry, 2006, see also 2002; van der Kolk, 1999). More recent neurobiological research identifies the effects of trauma on the body (Kendall-Tackett, 2000; Rothschild, 2000, 2003; Streeck-Fischer & van der Kolk, 2000), and supports the need to include the body in trauma therapy. There are newer forms of body-based therapy with theories and techniques similar to DMT (Aposhyan, 2004; Becker, 2003; Ogden & Minton, 2002; Ogden, Minton & Pain, 2006; Price, 2004; Rothschild, 2000, 2003). However, more modification of these therapy methods for adults is needed to make them applicable for children. Over the past ten years non-DMT therapists began to make changes and/or additions to their techniques to address new research on the effects of trauma and difficulties associated with using verbal therapy methods with this population. More research is needed on the use of DMT with this population that incorporates new literature and research from other fields. In
addition, dance/movement therapists need to help therapists in other fields recognize the benefits of DMT for these clients. This clinical DMT model is an attempt to incorporate the literature and research from other fields and to stimulate communication with these therapists who also treat this population.

5.2 DMT Clinical Model: Model Description

The clinical model created as the outcome of this study has a long-term, closed group, body based, and child directed format. The model is divided into three phases; the beginning, middle, and end phase. Each phase contains treatment categories that were created by combining literature on the effects of trauma and sexual abuse in children, and literature on treatment methods used in non-DMT therapy for this population. This clinical model is structured on a long-term treatment format because sexually abused children need time to work at their own pace, to address their experiences, and develop coping and social skills to move forward in their lives (Dripchak, 2007; Jones, 2002; Ryan & Needham, 2001). Some therapists like LeMessurier & Loman (2008) believe that in-depth work in therapy for sexually abused children doesn’t begin until the second year of treatment. The rate of progression in this therapy depends on how quickly or slowly the children want to disclose information about their abuse experiences (London, Bruck, Ceci & Shuman, 2005) and work through their issues. If these children are pushed or rushed during therapy they have an increased risk of becoming hyper-aroused, overwhelmed, and re-traumatized. By using a child directed format for this clinical model, the therapist provides structure and support for the group but allows the children to control the pace as they work through their traumatic experiences.
This model is designed to be used only with children who were victims of sexual abuse. However, overall the literature supports inclusion of non-offending caregivers in the therapy process in some form (Cohen, Deblinger, Mannarino & Steer, 2004; Hill, 2006; Lovett, 2007). To address these findings, this clinical DMT model can be easily incorporated into a multi-model treatment program that also involves non-offending caregivers and families in any way that will help the child. It is expected that a treatment program for sexually abused children will provide services to benefit the children outside of therapy that are consistent with the recommendations in this model. This model targets the areas of treatment where DMT can be most successful and provide unique contributions. The literature indicates that individual children may have needs that surface during therapy that can not be met using a single clinical model and treatment approach. Therefore, it is not possible for this clinical model to address all possible issues that may arise before or during therapy.

Although a group format is used for this model, is it is important that therapists using this model know that individual therapy is sometimes suggested for certain clients to prepare them for group therapy or in addition to group therapy. In contrast, much of the literature on DMT with sexually abused and otherwise traumatized people involves single case studies rather than group therapy. It was difficult to decide between using individual or group format for this clinical model. A group format was often used and/or recommended in the literature for treating children who were victims of trauma or sexual abuse specifically (Buckland & Murphy, 2001; Carbonell & Parteleno-Barehmi, 1999; Harris, 2002; Truppi, 2001). Many researchers and clinicians believe that a group format can help reduce isolation, provide support and modeling, and opportunities for role-
playing (Cohen & Mannarino, 1998a; Jones, 2002; King et al., 2000; Tourgny & Hébert, 2007). However, group formats can make it more difficult for the therapist to ensure that each child is able to work through his or her issues at his or her own pace. Even when children are in control of their level of participation, and the pace they choose to work through their experiences, simply observing other children work through their issues can be re-traumatizing for children. Therapists will encounter clients that need individual therapy instead of group therapy. They need to continually assess the individual group members to remove children that need individual therapy or additional support services that can not be met by being in a group.

Although there was limited research concerning the differences in effectiveness of closed versus open group formats a closed format was chosen for this clinical model. Building trust is difficult but essential in therapy for these children and adding new people continuously to the group would make it more difficult to build this trust. This clinical model is body based to target the body level issues that therapists observe in sexually abused and otherwise traumatized children. The decision to make this clinical model body based was made following repeated recommendations in the literature, within DMT and other fields of therapy, to involve the body in trauma treatment.

5.3 DMT Clinical Model: General Baseline Considerations

Since abused children are a very diverse group with complex issues, and no set syndrome is seen in most children, it is difficult to make general statements about treatment structure and methods. It is challenging to design a treatment model that is set and specific with interventions that treat specific symptoms. Treatment providers need flexibility when working with this population and must be ready to adjust interventions
for individuals or a group based on their client assessments. Due to the unique and challenging qualities of this population, the clinical model presented here does not have a set number of sessions and certain interventions that must be used. Instead, it provides information informed by the treatment methods of other fields outside of DMT on how to use DMT to address the most important issues identified from the literature. Although this clinical model is designed with a long term format, it is recognized that long term therapy is not always possible so the important categories, concepts, and therapeutic structures to address in a limited amount of time are highlighted later on in the study.

Regardless of the themes selected for the therapy process, it is crucial that the therapist works to develop a trusting, therapeutic relationship with each child client (Boyd Webb, 2006; Frank, 1997; Griffith, 1997; LeMessurier & Loman, 2008). This relationship forms a foundation for successful therapy and helps the child feel safe, supported, and hopefully more willing to work through his or her abuse experiences and make positive changes (Crenshaw & Hardy, 2007; Henry, 1997). In addition, it is important that therapy methods used with sexually abused children are child centered and based on the needs of each child and the child’s reactions to the therapy experience, rather than on the beliefs of the therapist (Crenshaw & Hardy, 2007; Henry, 1997).

In addition to the challenge to create an effective treatment model, therapists working with sexually abused children can feel overwhelmed and distressed due to transference and countertransference experiences during direct involvement with children that are disclosing negative experiences. Ben-Asher & Koren (2002) describe how dance/movement therapists can experience somatic transference and countertransference due to the direct involvement of the therapist’s body in therapy. While these experiences
can make the therapist physically ill, they can provide crucial information for treatment of these children. Dance/movement therapists and non-DMT therapists need to have a self care plan when working with sexually abused and otherwise traumatized children. This plan will help ensure that therapists are aware of these challenges and remain safe so that they can provide the best possible therapy for these children.

5.4 DMT Clinical Model: Rationale and Overall Goals

5.4.1 Rationale

This clinical DMT model is based on the continued currency of foundational DMT literature and a synthesis of related literature that supports body based therapy methods used in treatment for children who have been sexually abused. Children often learn about their world through bodily experiences that establish their emotional, social, physical, communicative, and cognitive development. Using DMT as the model for therapy with children is successful because movement is the language they use to communicate, and movement is naturally enjoyable for them and it helps motivate them to learn and remember the skills taught in DMT. In DMT with children, the therapist meets them on a primary, non-verbal level by using movement observation and interactions. Children often have rich life experiences that are difficult for them to express verbally. Dance/movement therapy provides them with ways to express thoughts and feelings through metaphors and symbols rather than with words (Payne, 1992). This process helps to restore a positive and realistic self-image for children damaged by sexual abuse. Dance/movement therapists are able to use both verbal and non-verbal methods to join children in their symbolic movement world and help them expand their communication skills. Better communication helps them gain self-awareness, awareness
of others, coping skills, and improved ability to form relationships (ADTA, 1999). Movement is a powerful and creative mode of healing that helps children re-connect with their core self to build new pathways for healthy development (LeMessurier & Loman, 2008). These concepts are particularly important for sexually abused children who struggle to express their experiences but need to be able to work through these experiences and heal. As described by LeMessurier & Loman (2008) dance/movement therapists have unique ways of creating relationships that are less direct and make the process easier for children who have difficulty trusting others. Dance/movement therapists notice movement qualities of children and use their own bodies to try on the child’s movement and attune to them on a body level. Therapists have found that young children are very responsive to this type of interaction and quickly engage in relationships when they notice someone connecting to them on a non-verbal level.

This clinical model targets school aged children because developmental literature indicates that children ages 6-11 have acquired skills on the cognitive, emotional, and interpersonal levels to allow them to successfully address the issues of sexual abuse. School aged children are beginning to focus on making friendships and are ready to extend their significant relationships beyond the family to include classmates, teammates, and close friends (Newman & Newman, 2006). This extension of friendships is advantageous in therapy sessions to help children build therapeutic relationships with the therapist and other group members. During this stage of development, these children advance in their ability to reason about their physical world that helps them deal with more complex social situations. Their experiences dealing with these situations help children develop flexibility and a broader perspective on problems (Newman & Newman,
School aged children who have been sexually abused may be more capable of understanding the complex situation of sexual abuse and tolerate the longer time needed in therapy. In addition, school aged children begin to acquire many new abilities, and become skilled learners by contributing what they already know to the performance of new tasks (Newman & Newman, 2006). This ability could help children in therapy to learn and understand concepts discussed and acquire new coping and social skills. Dance/movement therapy overall can be successful at working with a specific age group due to its developmental basis, and skills that can help children safely return to an earlier stage of development through movement activities. This clinical DMT model specifically targets school aged children’s abilities to think more autonomously, assert their independence, and establish themselves as unique individuals (Cincotta, 2002). Many sexually abused children do not have these abilities so this model uses activities that encourage these behaviors.

5.4.2 Overall Goals

There are several overall goals that are foundational for the treatment of sexually abused children and important for this clinical model. These goals are: 1) develop a trusting therapeutic relationship between therapist and clients, 2) create a safe and supportive therapy environment, 3) help clients work through their abuse experiences in some form at their own pace, 4) teach skills to empower and keep clients safe, 5) help clients feel more positive about and re-connect with their bodies and themselves as a whole person, and 6) give clients joyful, enriching experiences on many levels, including making meaningful connections with caring people both children and adults. In addition
to these overall goals, specific treatment goals or categories are present in each section of the model along with treatment concepts and therapeutic structures.

5.5 DMT Clinical Model: Guidelines for Structuring Therapy Sessions

This clinical DMT model was designed to be flexible with guidelines, concepts, and activities that can be adjusted to meet the needs of each group. It is important that before using this clinical model, the therapist assesses the needs of each child. The assessment should include determining: 1) the level of arousal and stability of the child, 2) whether the child ready to deal with difficult issues, 3) the use of any coping skills and/or defenses, and 4) the presence of immediate obstacles to treatment. Based on the assessments, adjustments can be made in how the model is used to promote successful treatment. During the process of therapy, continual assessment is recommended to monitor the status and needs of the group and each individual member, and make continuous adjustments in the therapy. Overall, the length of each phase and the selection of specific therapeutic structures for sessions depend on the therapist(s), the amount of time available, and the needs of the children in the group. It is recommended that each session is structured similar to Chacian style DMT groups consisting of a warm-up, theme development, and closure (Sandel, Chaiklin & Lohn, 1993). This will provide structure and consistency for the group and all of the necessary steps to work through the issues of sexually abused children.

5.5.1 Warm-up

There will be time for the children to verbally or non-verbally through movement express how they are feeling or express thoughts on other topics as a check-in. This part of the session will give the group a chance to warm-up their bodies physically to be able
to move more easily, and work on becoming more connected and aware of their bodies. The movement structures of the warm-up will also help establish a sense of grounding, support, and body level control for the child to use as a strong foundation for the therapy process. These structures will also help the children to feel physically and emotionally present in the here and now.

5.5.2 Theme Development

This is the time in the session when therapeutic structures are introduced that address the themes and issues of the group. The activities selected for each session will depend on the group’s needs, progress in the therapy process, and the structures used in previous sessions or earlier phases that need to be addressed more thoroughly. The therapist will stay flexible to the needs of the group as a whole, as well as each individual member who may not all be at the same place in the healing process.

5.5.3 Closure

Due to the intensity and often overwhelming quality of the issues dealt with in therapy, it will be important to end each session with time for activities that help children calm down, feel grounded, in control, and less anxious. This will be a time when children can chance express feelings about their experiences in the session, review what they learned, and say what they will practice at home before the next session. If possible, the group may come together, sit in a circle, and have something to eat and drink to provide nurturance, and a chance for some discussion (LeMessurier, 1990).

An overall summary of the three phases that address each treatment category of the DMT clinical model is presented in Table 4. Following the table, the model is presented in narrative form with more detailed treatment options.
Table 4. Summary of the beginning, middle and ending phases within eight treatment categories developed from a literature review and used to develop a DMT clinical model for sexually abused children

<table>
<thead>
<tr>
<th>Treatment Category 1: Body level issues; physical &amp; psychological damage to the body</th>
<th>Beginning phase</th>
<th>Middle phase</th>
<th>Ending phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>--Help children start being more aware of body</td>
<td>--Continue to work on increasing body awareness &amp; begin reconnection with the body</td>
<td>--Continue to work on all body level issues, either by repeating previous activities from other phases in this category or making changes in these activities to best meet the current needs of group members</td>
<td></td>
</tr>
<tr>
<td>--Use non-verbal techniques to allow for distance between body &amp; abuse experiences</td>
<td>--Address issues of boundaries &amp; personal space using concepts of kinesphere, defining personal space, &amp; being in control of that space</td>
<td>--Try to strengthen the positive &amp; healthy skills &amp; attitudes that have been developed towards the body in hopes that the children will continue to see their body in this new way</td>
<td></td>
</tr>
<tr>
<td>--Introduce issue of touch on basic level through props or touching of walls &amp; objects in therapy room</td>
<td>--Provide concrete experiences of body awareness &amp; personal space to restore integrity on a body level</td>
<td>--The activities that address touch used in earlier treatment categories may have either been postponed until this phase or still need to be worked on in more direct &amp; challenging ways to meet the needs of the children</td>
<td></td>
</tr>
<tr>
<td>--Strengthen boundaries &amp; become aware of how to keep body safe</td>
<td>--Work to help children feel more connected &amp; grounded, can help reawaken parts of the body that were cut off/made numb</td>
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<tr>
<td></td>
<td>--Address issues of touch more directly by providing therapeutic structures that involve safe, structured, playful touching to show children there is safe touch</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>--Remind children that they always have the right to say no to any form of touch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>--Address body attitude issues, movement issues &amp; physical issues by helping children move in new &amp; varied ways to expand their movement repertoire</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>--Address negative feelings &amp; attitudes towards their body by helping children make connection between them &amp; their abuse experiences</td>
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<tr>
<td></td>
<td>--Work through body/somatic memories using movement to access memories stored in the body</td>
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<tr>
<td>Treatment Category 2: Difficulty expressing emotions, over or under control of emotions, abuse memories easily triggered by sensations</td>
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<td></td>
</tr>
<tr>
<td><strong>Beginning phase</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>--Non-verbal techniques help child begin to be expressive in a less threatening way</td>
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</tr>
<tr>
<td>--Address children’s questions, concerns, thoughts about being in the group</td>
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</tr>
<tr>
<td>--Provide different types of sensory experiences (broken down into small manageable experiences) while practicing coping skills to keep safe and feel in control</td>
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<table>
<thead>
<tr>
<th>Middle phase</th>
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</thead>
<tbody>
<tr>
<td>--Continue to encourage non-verbal emotional expression</td>
</tr>
<tr>
<td>--Use metaphors, imagery, life narratives, movement stories for expression</td>
</tr>
<tr>
<td>--Help children learn to express emotions &amp; emotional memories directly related to abuse experiences &amp; expand their range of experiences</td>
</tr>
<tr>
<td>--Provide structures &amp; skills to safely express emotions</td>
</tr>
<tr>
<td>--Teach children awareness of body level warnings that indicate something has been triggered so they can initiate use of coping skills when this happens</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ending phase</th>
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</thead>
<tbody>
<tr>
<td>--The therapist helps the children practice techniques for emotional expression &amp; other related skills that were learned in the other two phases so that they can use them when therapy ends</td>
</tr>
<tr>
<td>--Since termination has a great deal of emotion associated with it, children need an opportunity to express their emotions to the group &amp; talk about what they have experienced</td>
</tr>
<tr>
<td>--For the children to have enough time to do this they need to know in advance when the therapy will end</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Treatment Category 3: Fear &amp; anxiety making child susceptible to hyper-arousal &amp; being overwhelmed, feel out of control</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beginning phase</strong></td>
</tr>
<tr>
<td>--Create sense of safety by using same place &amp; time, closed groups, provide structure</td>
</tr>
<tr>
<td>--Create safe holding environment/therapeutic container</td>
</tr>
<tr>
<td>--Teach coping skills so can feel more safe &amp; in control</td>
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</table>

<table>
<thead>
<tr>
<th>Middle phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>--Continue to help children feel safe, in control &amp; self-confident</td>
</tr>
<tr>
<td>--Practice coping skills &amp; being grounded</td>
</tr>
<tr>
<td>--Address issues more directly, eventually being able to connect what they express to what they experienced</td>
</tr>
<tr>
<td>--Use structured &amp; direct activities &amp; humor to reduce anxiety</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Ending phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>--Continue to set boundaries of space &amp; time for the group</td>
</tr>
<tr>
<td>--Due to specific issues of this category, approach termination &amp; saying goodbye with extreme caution</td>
</tr>
<tr>
<td>--Stress importance of keeping group experiences confidential even when therapy has ended</td>
</tr>
<tr>
<td>--Warn group well in advance when final therapy session will occur to reduce anxiety &amp; ensure that they are not surprised or overwhelmed when it is time to end therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Category 4: Didn’t experience childlike activities because preoccupied with keeping self safe, always trying to survive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beginning phase</strong></td>
</tr>
<tr>
<td>--Provide opportunities to engage in childlike activities that help children learn skills &amp; experience what it feels like to be a non-abused child</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Middle phase</th>
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</thead>
<tbody>
<tr>
<td>--Use therapeutic structures that require creativity such as improvisation &amp; experimentation with moving in different ways</td>
</tr>
<tr>
<td>--Encourage the use of creativity, play &amp; imagination</td>
</tr>
<tr>
<td>--Continue to provide opportunities to engage in childlike activities &amp; support learning to expand their playing abilities &amp; comfort in playing</td>
</tr>
<tr>
<td>--Creative movement tasks provide structure to contain thoughts &amp; feelings, this helps children feel safe to communicate &amp; work through their abuse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ending phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>--Continue to provide opportunities to engage in childlike, creative &amp; joyful activities</td>
</tr>
<tr>
<td>--Ask children what they like about these types of activities &amp; have them come up with other similar activities that can be done outside of therapy</td>
</tr>
<tr>
<td>--Themes related to termination &amp; saying goodbye can be incorporated into childlike activities to address these difficult topics in a fun, creative &amp; less intense way</td>
</tr>
<tr>
<td>Treatment Category 5: Developmental issues, unhealthy attachment patterns, lack secure sense of self/identity</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>Beginning phase</strong></td>
</tr>
<tr>
<td>--Assess developmental abilities/issuses using KMP</td>
</tr>
<tr>
<td>--Provide opportunities for exploring environment, interacting positively with others, learning about oneself, develop new skills</td>
</tr>
<tr>
<td>--Use non-verbal attunement &amp; empathy to help child experience &amp; develop healthy attachment patterns</td>
</tr>
<tr>
<td><strong>Middle phase</strong></td>
</tr>
<tr>
<td>--Use the body &amp; movement to help child move back safely to an earlier stage of development to learn needed skills</td>
</tr>
<tr>
<td>--Use KMP structure to show how to help child progress through stages of development on a movement level to gain skills</td>
</tr>
<tr>
<td>--Use dancing &amp; mirroring to re-choreograph early attachment issues</td>
</tr>
<tr>
<td>--Progress to higher developmental level by practicing different movement patterns &amp; rhythms</td>
</tr>
<tr>
<td>--Use group movement experiences to develop healthy attachments, relationships &amp; interaction styles</td>
</tr>
<tr>
<td>--Issues related to sense of self/identity are addressed by using the creative process of movement to explore these things that is easier &amp; more natural than verbalization</td>
</tr>
<tr>
<td>--Integrate/re-integrate parts of the self by incorporating all parts of self in the therapy process</td>
</tr>
<tr>
<td><strong>Ending phase</strong></td>
</tr>
<tr>
<td>--Focus on helping the group members practice &amp; eventually integrate what they learned in sessions so it becomes part of their repertoire &amp; will be easier for them to use outside of therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Category 6: Negative feelings: guilt, shame, and feel dirty. These feelings and negative cognitions cause damaged self-esteem, depression, suicidal thoughts, behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beginning phase</strong></td>
</tr>
<tr>
<td>--Develop feelings of empowerment &amp; trust by starting with child’s strengths &amp; accepting them at his or her current level of functioning</td>
</tr>
<tr>
<td>--Use structures that are simple &amp; provide sense of mastery to increase self-esteem</td>
</tr>
<tr>
<td>--Provide positive, joyful therapeutic structures to balance out negative cognitions and depression, and that involve whole person body &amp; mind to give fuller experience</td>
</tr>
<tr>
<td><strong>Middle phase</strong></td>
</tr>
<tr>
<td>--Acknowledge positive, intact &amp; healthy parts of children to build physical health &amp; self-esteem</td>
</tr>
<tr>
<td>--Give children chance to express verbally or non-verbally their feelings &amp; thoughts related to abuse, disclosure &amp; how they feel about themselves</td>
</tr>
<tr>
<td>--Use empathetic connections to: 1) give message to children that they are accepted &amp; important just as they are, 2) allow children to take on some of therapist’s ego strength &amp; self-esteem</td>
</tr>
<tr>
<td>--Improve children’s ability to use strong weight &amp; vertical plane, improve body attitude</td>
</tr>
<tr>
<td>--Provide positive &amp; rewarding experiences that establish/reinforce child’s positive qualities &amp; value</td>
</tr>
<tr>
<td><strong>Ending phase</strong></td>
</tr>
<tr>
<td>--Therapeutic structures from the other two phases can be repeated or altered to continue to work on the issues of this category</td>
</tr>
<tr>
<td>--Near the end of this phase, therapeutic structures can be used that synthesize the positive qualities each child has learned about themselves as a unique individual</td>
</tr>
<tr>
<td>--What is created from these structures can be transitional objects that will help the children make the transition out of therapy</td>
</tr>
<tr>
<td>Treatment Category 7: Problems with relationships, interactions, lack social skills, lack of trust, inappropriate behavior that leads to social isolation</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>
| --Develop sense of trust  
--Develop therapeutic relationships from being in a safe environment where they are accepted & from experiencing how positive relationships look & feel  
--Provide safe & supportive opportunities to learn and practice social skills, learn to be aware of others  
--Child is always in control of his or her level of participation  
--Start to develop group cohesion using structures such as cooperative games  
--Therapist use self as positive example of appropriate social behavior & positive interactions & provide reinforcement for positive behavior & interactions  
--Teach ways to successfully handle behaviors | --Continue to develop therapeutic relationships  
--Non-verbal techniques used to provide additional ways to connect with others  
--Encourage children to be expressive about feelings & thoughts  
--Behavioral issues: 1) use structure & rituals to overcome aggressive impulses, 2) expand movement repertoire so have more options of how to behave, 3) practice coping skills, 4) explore reasoning behind behavior & function of behavior | --The skills learned earlier in this category need to be reviewed to help the children understand how to use these skills outside of therapy  
--Cooperative games can be repeated to continue to practice social & interactional skills & to keep group cohesiveness strong to provide support as therapy ends |

| Treatment Category 8: Avoid remembering abuse experiences, have intrusive thoughts, relive traumatic memories, reenact trauma event, often can’t verbalize or can’t remember trauma experiences | NA | --Dance & improvisational movement allow child to work through trauma on all levels  
--Work through trauma more directly through movement reenactment & re-choreography  
--Give verbal & non-verbal message to children that it’s ok to talk or otherwise express their abuse. Also that they will be accepted & their feelings contained  
--Creative therapeutic structures help children work through abuse on both cognitive & body levels & provide unique ways to express experiences to others that may be too difficult to express otherwise | --Working through traumatic experiences takes a long time, this category requires as much work as possible in the time available  
--Some children will need more time to fully work through all of their traumatic experiences  
--Therapeutic structures from the middle phase can be repeated & therapist should make alterations depending on the needs of the group members & on what will most successfully help them address the issues of this category |
5.6 DMT Clinical Model: Addressing the Eight Treatment Categories

The DMT clinical model addresses the relevant treatment categories and associated effects of sexual abuse using a three phase format; beginning, middle, and ending phases. The overall goals of the beginning phase are: 1) provide a safe holding environment, 2) build trust both between the child and therapist(s) and between group members, 3) reduce isolation, 4) provide opportunities to share feelings about being in a therapy group, 5) develop group cohesion, 6) teach coping skills, and 7) assess all individual’s movement, behavior, and interactions with others. In the middle phase, children are encouraged to disclose and work through their traumatic experiences and address common themes and issues. Before engaging in the work of the middle phase, therapists need to help children practice the coping and safety skills they learned in the beginning phase to make sure they are able to use them successfully as a way to reduce the possibility of retraumatization when they express and work through their experiences. The main goals of the ending phase are to review new skills learned in therapy, address feelings related to termination and saying goodbye, and help the group members to transition out of being in therapy. A specific description of the DMT clinical model for each of the three phases follows. It includes suggested treatment categories to address in each phase and provides suggestions for DMT therapeutic interventions. All treatment categories of each phase are discussed in the order of how they would most likely be addressed in therapy rather than in numerical order. The interventions include concepts, and sometimes therapeutic structures, as exemplar for these categories and related effects. Some of the therapeutic structures described in the DMT clinical model came from the DMT literature in Matrix 4. The other therapeutic structures that are not specifically
cited were created based on general information on DMT, and information gained from my personal experiences in dance movement therapy with children. Although the interventions are generally applicable to most ages of children, they are designed to target school aged children specifically. It is important to note that throughout the therapy process, it is expected that therapeutic structures will develop as the therapist responds to emerging themes. Therefore, the therapeutic structures selected during therapy should be considered unique for each group of children. In addition, the order that individual categories are addressed may fluctuate with each group.

5.7 DMT Clinical Model

5.7.1 Beginning Phase

In the beginning phase of group DMT for sexually abused children, it is crucial to establish a safe therapeutic environment so children can learn about themselves and learn to trust the therapist and the other members of the group. This initial process creates a foundation for the rest of the therapeutic process. Without it, the children will not feel comfortable working through their abuse experiences and will not successfully address their complex issues (Herman, 1992; Rothschild, 2003). Children may be confused and wonder why they are even in a therapy group. Children often think that sexual abuse is a taboo topic and feel hesitant to talk about their abuse (Kornblum & Halsten, 2006).

It is important for the therapist to introduce the children to the structure of the sessions and the treatment overall. Therapists should describe how the DMT sessions are organized and what will take place in sessions, particularly if the movement activities will be foreign to many of the children in the group. It is important that all aspects of therapy for abused children are structured and predictable to help them feel safe, which in
turn will help them express their feelings and eventually work through their abuse experiences (Kornblum & Halsten, 2006). The children need to be introduced to the group process and to each other. Guiding the group to talk about why they think they are in therapy will build collaborative relationships and allow for themes to arise naturally instead of being directed by the therapist. It is beneficial for children and the therapist to establish group rules for safety and confidentiality together (Kornblum & Halsten, 2006) and create a way to end each session that will provide closure (Meekums, 2000).

In the beginning phase of DMT the therapist observes each child’s unique movement qualities and preferences to gain more information about the children and their needs. Part of the assessment of children in a group is observing reactions to various activities and experiences in the group, somatic or physical/medical issues, body and movement issues, and behavioral issues. The therapist uses the assessment material to recognize possible effects of sexual abuse in the group members and select goals and activities for the therapy sessions (Kestenberg Amighi et al., 1999). Although assessment is not the main focus of this model, the importance of observing each child individually as well as interactions with peers, is recognized for the beginning phase of therapy.

There are specific treatment categories, previously identified, that are important to address in this beginning phase. Below are DMT therapeutic interventions that address these categories and include concepts and in some cases therapeutic structures as exemplar for these categories and associated effects.

Treatment category 3: Abusive, traumatizing experiences that children can not control can be terrifying, confusing, and painful. Abuse can cause strong feelings of fear and high levels of anxiety that make children susceptible to hyper-arousal or becoming overwhelmed physically and emotionally. These issues affect various aspects of a child’s life and create challenges for therapists working with them.
Therapeutic interventions:

Sexually abused children are susceptible, due to their stress response system, to quickly become and stay hyper-aroused, which can easily interfere with the therapeutic process (Perry, 2006). Therefore, it is essential to create a sense of safety in the beginning phase for these children to be able to start the healing process. A sense of safety can be created by using the same space for every session and by keeping the groups closed (Kornblum & Halsten, 2006). Another way is to reduce anxiety and hyper-arousal by providing structure. Structure can increase the children’s capacity to inhibit impulses. However, therapists must proceed with caution as rules, boundaries, and other forms of structure can feel threatening to a child and may remind him or her of their abuser’s controlling behaviors (van der Kolk, 2003). Most school aged children are already experiencing many changes such as starting elementary school and changing from elementary to middle school. The changes are more complex with sexually abused school aged children who experiencing natural school changes as well as being bombarded with abuse related changes. Therefore, it is particularly important to provide rituals and routines in therapy with these children as a way for them to cope with the many changes, issues, and experiences that occur (Cincotta, 2002). Therapeutic structure can be created through a predictable routine, such as set beginning and ending rituals that help to center and ground children (Kornblum & Halsten, 2006). Also, the use of a warm-up period, theme development, and closure for each session, as suggested for this model, provides another level of structure for these children. Children’s anxiety and hyper-arousal is reduced when they feel safe and more in control of their behavior and
experiences (Perry, 2006). The therapist also needs to create a safe holding environment or safe therapeutic container for the therapy sessions (Kornblum, 2008; LeMessurier & Loman, 2008). This environment helps children feel safe, experience respect of their boundaries, and trust the therapist and the therapy process (Kornblum, 2008). The therapist can encourage group members to participate in the development of group rules, and talk about the importance of confidentiality. Containment is often provided by having each child create his or her own safe space in the room. This space can be used as a refuge when a child is over-aroused or threatened to give them a sense of safety and boundaries (Kornblum, 2008).

Despite the therapist’s efforts to explain how therapy will proceed and provide a sense of safety, children can still become anxious and hyper-aroused in response to triggering stimuli that perhaps neither the child nor the therapist recognizes. It is important that therapists teach these children coping skills to use when they begin to feel hyper-aroused to make them feel more in control. The therapist may work with the children to create a set ritual to do when they begin to feel overwhelmed by experiences such as: 1) take a deep breath, 2) say something encouraging to themselves, 3) move to a specific “safe place” in the therapy room, and 4) find an object in the room to focus on to help connect them to the present moment in the safe environment. Learning skills to feel in control when they are anxious or hyper-aroused during the beginning phase will be a crucial skill for these children in the middle phase when traumatic experiences are directly addressed and there is a greater possibility of re-traumatization.
Treatment category 5: Sexually abused children often lack certain developmental skills or have had interruption and damage in their development. They may form unhealthy attachment patterns or not develop a secure sense of self or identity.

Therapeutic interventions:

In the beginning phase it is important for the therapist to assess the child’s age appropriate abilities and possible developmental issues through the observation of his or her movement abilities and weaknesses. Dance/movement therapists use the Kestenberg Movement Profile (KMP) as a tool to understand movement on a developmental level, know what to observe in the client’s body and movements, and how to make decisions about a client’s developmental level and goals for therapy (Kestenberg Amighi et al., 1999). Assessments of the areas of behavioral, social, emotional, and cognitive domains will also be important. All assessment information combined will give the therapist the ability to match the sequence of therapy experiences with the children’s level of neurodevelopment (Perry, 2006). Specific KMP therapeutic structures to gain insight into a client’s problems include giving movement directives that elicit the use of different spatial planes, pre-efforts, Efforts, tension flow, and shape flow. By detecting the presence or absence of these aspects of development, and observing a child’s body attitude, the therapist can determine the child’s developmental level (Kestenberg Amighi et al., 1999). A dance/movement therapist that is assessing sexually abused children must be careful to not overwhelm them by asking them to do too much at one time or in quick succession. The therapist can get a reasonable idea of a child’s developmental issues based on his or her movement by giving them simple movement tasks or by observing his or her movements as part of other less structured and directive therapeutic structures. When
making assessments of children in a group, the therapist needs to try and ensure that a child doesn’t feel singled out for his or her developmental issues. Sexually abused children often feel socially isolated, and singling them out for their issues would only make this worse. Also, singling a child out at this stage would be counterproductive when the therapist is trying to reduce isolation and build group cohesion.

Developmental issues are particularly prominent for school aged children who have been sexually abused because at this point children begin to focus on making relationships beyond their family, particularly with peers. They become more concerned about what others think and how they appear to others, which makes self-evaluation, interactions, and relationships more complicated for these children (Newman & Newman, 2006).

Non-abused children have opportunities during healthy development to explore their environment, interact positively with others, learn about themselves, and develop new skills for a variety of tasks (Newman & Newman, 2006). Sexually abused children often don’t have all of these experiences to develop in a healthy way.

During the middle phase of therapy, the dance/movement therapist will use information from their assessment of the children to select techniques that will guide them back to earlier developmental stages, some are pre-verbal, to acquire skills (Loman, 1998). These techniques are not used in the beginning stage to avoid the possibility of exposing traumatic memories from a child’s earlier abuse before the child has acquired positive coping skills to deal with these memories. The same positive coping skills need to be acquired before the therapist guides the child to an earlier stage of development.
Forming healthy attachments is an essential part of healthy child development (Newman & Newman, 2006). Unfortunately, many sexually abused children develop insecure attachment patterns that negatively affect future relationships (Bannister, 2003; Cook et al., 2005). Therefore, it is important that these children have an opportunity to form healthy attachments with the therapist and others. Dance/movement therapists give the child opportunities to move with them to encourage attachment and bonding (LeMessurier & Loman, 2008). In DMT the therapist uses his or her own body as a therapy tool to connect with tensions and emotional states in the child, and have bodily experiences of the child’s struggles in his or her own body (MacDonald, 2004). Therapists also use non-verbal attunement and empathy to show children how attachments are formed and feel. Techniques such as attunement must be used with caution to not trigger traumatic memories for the child that may occur if the therapist becomes physically or emotionally close too quickly. At this point in therapy, a main goal is forming healthy attachments as part of developing therapeutic relationships. These positive attachments and relationships with the therapist and their peers will provide a supportive foundation for children to feel safer taking risks and working through their trauma directly.

*Treatment category 7*: Sexually abused children often develop problems with relationships, social skills, and social interactions with other children and adults. They learn that they can not trust some adults. Abused children can develop age or socially inappropriate behaviors, for example precocious sexual behavior, that disrupts social interactions and leads to social isolation.

Therapeutic interventions:

A goal central to this category, and the beginning phase overall, is to develop trust between each child and the therapist and the children and their peers in the group.
Sexually abused children will most often enter therapy with diminished trust of others because they have been betrayed, often by the adults they should have been able to trust. To gain the children’s trust, a therapist must assure them that they can handle intense experiences and are not afraid to hear about the children’s abuse related feelings and experiences. Confidentiality must be continually stressed and maintained within the group with an understanding that the therapist may have to talk to other trusted adults to keep the children safe if they are in danger (Kornblum, 2008). It is important that the therapist doesn’t make promises at any point in therapy, such as complete confidentiality, that they can not insure will be possible. Once a level of trust is established, therapeutic relationships can develop (Frank, 1997).

Therapeutic relationships established in the beginning phase are essential to the entire therapeutic intervention. The development and strengthening of these relationships is a part of many different therapeutic structures. When a child is in a safe environment, the ability to be themselves and still to be accepted and valued continually reinforces his or her relationships with group members and the therapist. During therapy, a child may have his or her first experiences with how positive, healthy relationships look and feel. Eventually, with repeated positive experiences, sexually abused children will begin to develop skills that are needed to have healthy relationships and interactions. These invaluable experiences will help the children’s brain cancel out negative associations or reduce their overgeneralizations of adults that were made based on their abuse experiences that are negatively affecting their relationships with others (Perry, 2006).
Social interactions and making connections with others are often difficult for sexually abused children. They need safe and supportive opportunities to learn and practice these skills. First, the children need to become more aware of others to become less socially isolated. A circle formation is often used in DMT sessions to stimulate children to become aware of others in the group (Kornblum & Halsten, 2006). A circle formation can be used during a warm-up or while doing other activities during the session. Once children have expanded their awareness of others, they need to learn social skills to make connections and interact with others.

Interacting and connecting with others on a non-verbal level in DMT, through movement, is often easier and less intimidating for children than using words. Movement is particularly helpful in the beginning phase when the children’s defenses are very strong. Movement helps a child bypass defenses against connecting with others and overcome hesitation to connect with others based on negative experiences with abuser(s). For example, using the circle formation, the therapist can lead the group members in creating a rainstorm using the sounds of their bodies. The therapist first starts rubbing his or her hands together, and then asks the child next to them start the same movement and the activity progresses around the circle. Once everyone is rubbing their hands together the therapist can change the movement, then the first child changes to the new movement, and it goes around the circle again. The movements used are rubbing hands, snapping fingers, clapping hands, then stomping feet. Once the pattern is completed the order is reversed so they end up rubbing their hands together and then stop completely. Through this therapeutic structure, the group is able to interact and connect with each other in an easy and non-threatening
way. The therapist may need to alter the movements depending on the ability and comfort level of the group members. Members are always given the option of listening to the rain storm instead of participating if it is more comfortable for them. It is important that sexually abused children always know that during therapy they are in control of their actions and how they use their bodies as long as they are safe. With most of these children their abuser was always in control and told them what to do; therefore a therapist never wants to create this feeling in therapy.

Once children begin to make connections with other children in the group, the therapist can start to promote group cohesion. Being part of a group that is working together is an important experience for all school aged children. As part of natural development, school aged children begin to participate in activities such as team sports that help them start to gain a sense of team success in addition to individual success. Membership in a team or group teaches these children interdependence, and cooperation (Newman & Newman, 2006). Since sexually abused children often have developmental issues, they often need help to understand the concepts of a group and group cohesion. Dance/movement therapists can use cooperative games to build group cohesion and provide opportunities for interactions and for practicing social skills. A suggested cooperative game is called the group juggle. Everyone stands in a circle and gets to throw the ball one time to someone. They repeat the same sequence of passing the ball and practice it several times. After practicing the pattern, the therapist adds another ball so the group is now juggling two balls. This structure is specifically chosen to get children to focus on others, solve problems, and work together to reach a goal. The physical and concrete aspects of this game provide an
.observable example of either group cohesion or a lack of it. After this game is completed, or if the group becomes frustrated, the therapist can facilitate a discussion about techniques that helped the children to be successful in the game.

During the beginning phase it is most important to provide the children with examples of appropriate behavior and teach them successful coping skills to handle their behaviors so that they can stay safe. Some examples of coping skills are taking deep breaths, counting to ten, and removing oneself from an activity to take a break. Behavioral issues can be addressed by providing children with verbal and non-verbal models of appropriate social behavior and positive ways of interacting (Kornblum & Halsten, 2006). The therapist can point out and encourage positive interactions and behavior that they observe in members of the group. Behavioral issues will have to be continually addressed throughout the therapy process on different levels.

**Treatment category 4:** Sexual abuse during childhood severely disrupts a child’s opportunities to engage in childlike activities. Children become so preoccupied with keeping safe that they miss chances to play and use their imagination to interact with the outside world. Sexually abused children are constantly trying to survive physically as well as psychologically.

**Therapeutic interventions:**

The development of a safe therapeutic space and the child’s growing trust during the beginning phase encourages them to engage in childlike activities such as play, make believe, and storytelling that come more naturally to them in non-abusive environments. These childlike activities are easily incorporated into DMT and help teach children important skills they may have not developed due to their abuse. When a child is constantly thinking about how to keep themselves safe, and all of his or her behaviors are geared towards survival, there is no room to be playful and
imaginative. In this category, the therapist tries to engage the children in childlike activities that are pleasurable and do not contain trauma-related material that can trigger defensive reactions or a habitual reaction of fight/flight/freeze. When a child can engage in these types of activities he or she will be able to experience the feelings of safety and joy that non-abused children experience during play (Streeck-Fischer & van der Kolk, 2000). Some children will begin to engage in these types of activities fairly easily once they are no longer preoccupied with surviving. However, some children will need specific therapeutic structures to support them in learning how to be a child. A therapeutic structure that provides these types of opportunities is having children pretend to be different animals. The therapist can ask each child to choose an animal to be and the group moves together across the floor as their chosen animals, or the whole group can move together as the same animal. The therapist can also help the group by giving or asking for suggestions of how a particular animal may move and by providing encouragement to the children as they move. This is a typical activity for school aged children and at the same time helps children learn to be creative and flexible in their play by expanding their movement repertoire. These skills will continue to help the children as they progress through therapy. At this point in the therapy process, the most important focus is to give the group opportunities to act like a child and begin to understand how this feels. The more deep seeded issues of this category will be addressed in the middle phase.

Treatment category 2: Sexually abused children have difficulty expressing their emotions. They may either be unable to control their emotions or have the need to over-control them. Their memories associated with abuse contain specific sensations, sounds, and images. If these sensations are triggered, they easily cause flight or fight reactions.

Therapeutic interventions:
Ideally, a therapist wants to help sexually abused children express their emotions, particularly those connected to abusive experiences. However in the beginning phase the children need to simply learn how to be more expressive, regardless of what they are expressing. Sexually abused children are often unable to express themselves verbally because their often constant high level of arousal is interfering with the functioning of Broca’s area of the brain, which is used to put feelings into words (Rauch et al., as cited in van der Kolk, 2002). Therefore it is essential that non-verbal forms of expression are taught and explored for these children. During this initial stage when they have difficulty expressing themselves, DMT provides ways for them to be expressive non-verbally (Kornblum & Halsten, 2006). Movement is used as a non-threatening form of emotional expression by getting the children to use different movement qualities (Efforts) (Lumsden, 2006). Rather than encouraging an individual child to directly express his or her feelings of anger, Goodill (1987) suggested that the dance/movement therapist may have the group use strong, quick movement qualities that are often associated with anger. The therapist doesn’t need to make a connection between the movement qualities and feelings unless the children bring it up on their own. A specific therapeutic structure that helps children practice being more expressive is to have each child in a group choose a movement to express either something about themselves or his or her thoughts or feelings about being in a therapy group. A child will demonstrate his or her movement and the other group members then repeat the individual’s movement together as a group, if the child who demonstrated feels comfortable with this process. Often in beginning therapy children have questions, concerns, or thoughts about being in a therapy group.
that they may need help expressing. These are important issues to address in this beginning phase so that each child can feel comfortable proceeding in therapy. Since children can more easily experience feelings on a kinesthetic level, this technique is used until they can express their feelings on a logical, cognitive level through verbal processing that might not occur until the middle phase of therapy (Truppi, 2001).

Sexually abused children learn to control their emotions and sensory experiences because they are afraid of triggering a fight/flight/freeze reaction or re-experiencing their trauma. These are conditioned responses to certain reminders of the trauma that are engrained (van der Kolk, 2002). Valentine (2007), in her work with adult survivors, emphasizes it is important to encourage clients to have fuller experiences using all of their senses. As was described in the previous treatment categories, therapists need to continually teach coping skills and have the children practice them when they feel they are becoming overwhelmed to avoid fight/flight/freeze reactions that can lead to re-experiencing trauma. To ensure that the children will not feel overwhelmed by having numerous sensory experiences, it is important that the exposure is broken down into small manageable experiences that occur in a safe, therapeutic holding environment. For example, a dance/movement therapist may have the group toss different types of balls to one another, each one providing a different sensation; soft, firm, fuzzy, squishy etc. After playing with these balls, the children can describe the qualities of the balls and how it felt to use them. It is important that the therapist is careful when choosing props and other materials to use in therapy as certain items can cause a lack of control, or trigger traumatic memories and sensations. Another therapeutic structure of DMT is to provide music with strong
rhythms for use with movement structures to elicit different sensations in a contained and safe way. Strong rhythms that occurred during prenatal development are connected to sensations of being warm, soothed, and safe. These rhythms, represented by the mother’s heart beat for example, continue to elicit these types of sensations in the brainstem, making the neural systems of this part of the brain more organized and regulated (Perry, 2006). Dance/movement therapists use this stimulation of organization when working with sexually abused children who feel the need to control their experiences to stay safe.

It is important to try and schedule co-therapists when working with sexually abused children. During groups, sexually abused children often experience deep emotional material and they may need one-on-one attention when intense issues are triggered, which is easier with two therapists. Also, co-therapy makes it easier for an individual therapist to deal with issues of countertransference (Kornblum & Halsten, 2006). Unfortunately, co-therapy is not always possible so other adjustments should be arranged to deal with these possible issues.

Treatment category 1: Sexual abuse is a negative experience that directly involves and damages a child’s body, physically and psychologically. Sexually abused children often develop body level issues such as dissociation, somatic issues, negative body image, and negative body/somatic memories.

Therapeutic interventions:

Sexual abuse directly involves the body and causes body level issues therefore, it is important that therapists address the body in therapy. However, in the beginning phase body issues must be approached very carefully to keep the child safe and avoid re-traumatization. An important area to address in terms of this category is helping children to become more aware of their bodies. In DMT, body awareness is
addressed by having children use their body positively in movement and by encouraging them when they use their bodies in new ways. Becoming aware of their bodies may be difficult for these children and could connect them with traumatic body level memories, and therefore this needs to be approached slowly and with care. The new body movements they experience are very different from the physical or verbal experiences of most traumatized and sexually abused children. The non-verbal DMT techniques allow children to create distance between their bodies and their traumatic experiences rather than requiring them to make a connection between their bodies and their abuse during this beginning phase of therapy. Creating distance between themselves and their trauma related feelings, sensations, and memories, allows them to participate without becoming overwhelmed and avoidant on a physical and psychological level (van der Kolk, 2002). Having these children engage in any type of movement is progress from the status of many abused children who come into therapy disconnected or dissociated from their bodies. An example of a therapeutic structure is to have the children play with props that encourage new sensory and motor experiences (Lumsden, 2006). On a basic level, the therapist can provide therapeutic structures such as using a scarf to facilitate safe and controlled movements, sensations, and feelings of touch. The therapist may request that the children sit in a circle and each play with a scarf, either in their own way or by following the therapist’s movements. The scarf, like other props, has a unique physical sensation when used and encourages certain movements. After the group members have had a chance to move with their scarf, the therapist may ask them to describe how it felt to use this prop or what they liked or didn’t like about using it.
Touch can also be introduced by having the children touch different parts of the room, such as the wall, floor, or objects in the room (Meekums, 2000). Again, this provides the sensation of touch on the body but allows the child to be in complete control and not have to make physical contact with another person, which would be too intense at this point in therapy. The issue of touch is important to address however, it will be most likely very overwhelming for sexually abused children to address in the beginning phase. The therapist must continually remind the group members that they can always choose to not do something if it feels unsafe to them.

A part of creating positive body experiences for children is helping them learn to strengthen their body boundaries and become more aware of how to keep their body safe (Kornblum & Halsten, 2006). In the beginning phase, the concept of boundaries is addressed on only the most basic level. This reduces the chance of overwhelming the child by making them directly confront the violation of his or her body boundaries during the abuse. It is most important to simply make them aware that these boundaries exist, and that they have the right to protect them.

_Treatment category 6:_ Although sexual abuse is clearly the fault of the perpetrator, abused children often feel shameful and dirty about the experience. They feel guilty because they did not stop or disclose the abuse earlier. These feelings and negative cognitions damage self-esteem and can lead to depression, and suicidal thoughts and behaviors.

Therapeutic interventions:

In this treatment category there are issues concerning intense feelings, many that are directly related to abuse experiences. Therefore in the beginning phase of therapy, it is most important to always start from a child’s strengths and accept them at his or her current level of functioning. This builds empowerment and trust
(Kornblum & Halsten, 2006) because they can feel accepted, just as they are, even with all their perceived negative qualities. Feeling empowered, trusting, and accepted is most important in this phase. The issues and related intense feelings can be more directly addressed in the middle phase when the children have the necessary skills to work through these issues in a healthy way.

Therapy in the beginning phase should include therapeutic structures that are simple and give the children a sense of mastery. These types of therapeutic structures help to improve their self-esteem in an indirect way and provide concrete examples of their abilities. Experiencing a sense of mastery and pleasure also helps these children eventually overcome their habitual fight/flight/freeze reaction (Streeck-Fischer & van der Kolk, 2000). This occurs because these types of experiences help the children to feel a sense of competence and predictability that allows them to gain more control over their level of arousal and be flexible when faced with challenges (van der Kolk, 2003). Their lives up until this point have most likely been filled with scary, painful, and uncontrollable experiences so it makes sense that they only have negative cognitions concerning themselves and their life. In therapy, the therapist can provide structures that are fun, silly, and joyful to provide positive experiences that can balance out their negative cognitions and depression. Dance/movement therapy therapeutic structures for this purpose include doing fun, silly, and exaggerated movements as part of a warm-up or theme development, sometimes using lively music. These structures safely involve the whole person, body and mind, giving them a fuller experience that he or she can remember on a physical and emotional level. By giving the children the opportunity to move in these ways, the therapist is showing
them that there are strong positive aspects to life, and that they have positive qualities as a person.

5.7.2 Middle phase

Before beginning the middle phase of the clinical model, the therapist needs to make careful assessments of each child in the group to determine where the child is in the therapeutic process. The therapist should attempt to determine whether each child appears to feel safe in the group and trusts the therapist and the other group members. The children need to feel ready to talk about and work through their abusive experiences (Meekums, 2000) to move onto the middle phase of the clinical model, and be successful using positive coping skills. Because all group members will not reach this point at the same time, it is important to give each child a choice in the level of participation and in the amount of personal disclosure. Instead of pushing members to do all activities, dance/movement therapists can use issues identified through the clients’ verbalizations, and/or movements in the beginning phase, to sequence sessions that are more flexible to meet the needs of a specific group (Valentine, 2007). Many dance/movement therapists consider that a child who isn’t actively participating will still gain information from being present in the room and trusted as a member of the group. However, it is possible that just observing other children working through their issues can be re-traumatizing. At this point in the process the therapist may need to make decisions about the readiness of children in the group and find an alternative treatment solution for children who are not ready for the middle phase. Removing a child from a group is a difficult decision as it can create feelings of abandonment in the child, thoughts that he or she did something
wrong to cause them to be removed from the group, and anger towards the therapist for his or her decision to disrupt the experience.

To complete a successful middle phase and protect children against re-traumatization, they need to continue to learn and use effective coping and safety skills. A benefit of working with school aged children is that they are developing numerous new abilities, and becoming more advanced learners by learning to contribute abilities that they already have to doing new tasks (Newman & Newman, 2006). This ability can help them to learn and use coping skills throughout the middle phase as abuse related material and other difficult tasks arise in sessions. Eventually they should be able to also use these skills at home. Many therapists choose to help children work through their abuse experiences initially by using a less direct approach to the abuse material (van der Kolk, 1988) and then gradually begin to address the abuse experiences more directly. In DMT, therapists use unique techniques such as: metaphors, imagery, improvisation, role-playing, and props, to provide distance between the child and his or her abusive memories and help them gradually work through his or her negative experiences. Movement is used as a tool to help children express their abuse narrative, feelings, and experiences without needing words to describe them (Goodill, 1987). The therapist helps them work through their memories indirectly with the hope that eventually they can address them more directly.

A specific description of the DMT clinical model for the middle phase is presented next. It includes the treatment categories to address in the middle phase and suggests DMT therapeutic interventions that include concepts and at times examples of therapeutic structures to address the categories and associated effects.
Treatment category 7: Sexually abused children often develop problems with relationships, social skills, and social interactions with other children and adults. They learn that they can not trust some adults. Abused children can develop age or socially inappropriate behaviors, for example precocious sexual behavior, that disrupts social interactions and leads to social isolation.

Therapeutic interventions:

Behavioral issues displayed by sexually abused children, that were identified and briefly addressed in the beginning phase, are dealt with more intensely in this phase. Children are usually ready at this phase to explore the reasoning behind their behavioral patterns, although depending on the ages of the children in the group this can be more difficult. In general, school aged children are starting to improve in their ability to reason about the world they live in, which in turn, helps them deal with complex situations, particularly social ones (Newman & Newman, 2006). This ability to reason will most likely also help them understand their complex behavioral patterns more easily. Experience managing these situations and issues may help children develop flexibility and a greater perspective on these things (Newman & Newman, 2006). The therapist works to help them understand the function that their behavior previously served for them and how continuing to behave in this way is causing them problems. It is important for the therapist to always remember to respect the child’s behavior, because like his or her other defenses, it helped them survive experiences that are far outside the scope of normal childhood experiences. They need to voice this understanding of behavior to the group so that the children do not feel bad about their behavior, but instead recognize how they can become happier and healthier by making behavioral changes. Sexually abused children will be unlikely to give up these self-protective behaviors until they have learned to be
physically competent and secure, which occurs when they are able to regulate their arousal level (van der Kolk, 2003). The need for change in their behavior should be addressed slowly as to not cause them to revert to age inappropriate behavior or feel out of control. In this clinical model, behavior issues are not addressed directly until the middle phase when the children are more likely to have developed these abilities.

In this treatment category therapists need to continue to teach coping skills and give opportunities to practice these skills because they are necessary to address behavioral issues. In DMT therapists work to expand a child’s movement repertoire because this gives them more ways to deal with a situation or a feeling, which is similar to using traditional coping skills (Valentine, 2007). Specific coping skills that are taught in DMT to use for behavioral issues include: punching a pillow, going for a walk, and expressing feelings through movements. These actions provide a cathartic release for issues and feelings that could cause behavioral problems, while keeping the child safe. Also, teaching children to use specific coping skills such as these allows them to learn appropriate ways to behave to deal with issues and feelings.

Another effective coping skill particularly for a child that is angry, aggressive, or out of control is using the 4 B’s of self control: Breaks (squeeze hands together and bend knees), Breathing (take a deep breath), Brains (put hands on head and say “I can calm down”), Body (put hand on heart and feel body calming down) (Kornblum, 2002). Each of the four terms that are said while doing a specific movement makes children stop what they are doing, focus on themselves and their bodies, and be reminded of what to do when they are having trouble behaving safely and appropriately.
In addressing this treatment category, therapists must continue to work with these children to further develop therapeutic relationships while letting them still be in control of how much they want to participate. The use of structure and rituals can help these children overcome their aggressive impulses and discover the joy of working together with others (Harris, 2007). Dance/movement therapists provide support verbally and non-verbally through interactions with members of the group. Children aren’t pushed to express themselves verbally and are still supported in using non-verbal techniques. Non-verbal techniques such as mirroring, expressing and experiencing kinesthetic empathy, and meeting someone where they are at in the moment, provide additional ways to make connections and build relationships with children who have experienced damaging relationships. The use of a stretch cloth can help the group learn to work together, to make their bodies strong and grounded, and provide nurturance to each other (LeMessurier, 1990). Children are continually encouraged to be open and expressive about their feelings and experiences to the group to help them feel more connected to one another.

Dance/movement therapy techniques develop strength and trust by guiding a child to re-experience the ego-building individuation stage using strong rhythmic movement patterns and movement synchrony with strength. When a child is able to be passive as well as strong he or she is developing trust and can work to share more personal experiences with the therapist and the group (Goodill, 1987). The following trust exercise strengthens the child’s ability to build a trusting therapeutic relationship with group members and the therapist(s). First children are grouped into pairs, making sure that everyone feels safe. Next they practice making physical contact by
asking their partner if it is ok for them to place their hands on their partners back. Then one person leans back slightly, keeping his or her feet on the ground as their partner holds their weight with their hands on the partner’s upper back. Next the partners touch back to back, one person leans forwards taking the other person’s weight as that person leans backwards. This trust exercise helps the children practice asking for permission to touch, learning how to positively interact, and slowly building trust by experiencing physical support from another person in the group.

Treatment category 3: Abusive, traumatizing experiences that children can not control can be terrifying, confusing, and painful. Abuse can cause strong feelings of fear and high levels of anxiety that make children susceptible to hyper-arousal or becoming overwhelmed physically and emotionally. These issues affect various aspects of a child’s life and create challenges for therapists working with them.

Therapeutic interventions:

To help the children in the group still feel safe as they continue into the middle phase, it is important to still provide set boundaries of space and time and a safe therapeutic holding environment where children are in control of their participation (LeMessurier & Loman, 2008; Valentine, 2007). In addition, it is a good idea to keep a safe space in the therapy room that children can go to when they feel hyper-aroused as they did in the beginning phase. Specifically, the therapist should continue to increase the children’s sense of safety, control (Kornblum & Halsten, 2006) and self-confidence (Frank, 1997) by reinforcing and practicing coping skills that were taught previously in therapy. It is important to have children practice being grounded through structures such as pushing on a wall and feeling their feet connected to the floor. This is a coping skill that can channel their energy, and help them feel empowered and in control (Kornblum & Halsten, 2006). A specific therapeutic
structure that increases a child’s sense of safety, control, and self-confidence is called freeze dance. The therapist plays music or a musical instrument while the children move safely around the therapy room in any way they choose. When the music stops and the therapist shouts “freeze”, the children have to stop moving and freeze wherever they are. The therapist then plays music again and the process is repeated. This technique helps children learn that they have the ability to be safe and in control. Other stop and start structures can help children to work on impulse control (LeMessurier, 1990). Since in this phase children are practicing coping skills and other ways to feel safe, in control, and self-confident, they are ready to address the issues of anxiety, fear, and hyper-arousal more directly. Once children realize that others in their group have had similar painful experiences, a bond is created that encourages them to disclose material that can be anxiety-producing to them and cause over-arousal (Kornblum & Halsten, 2006). At first when disclosing such material, the therapist can guide children to use abstract movement qualities to disclose without having to link what they are expressing to a specific purpose, narrative, or relationship until they are more comfortable (Lumsden, 2006). Abstract movements allow children to feel in control as they experience sensations and emotions connected to their abuse (van der Kolk, 2003). Over time, when children are ready, the therapist will encourage them to make connections between their movements and what they have experienced. Making this connection is an essential part of treatment to help children process their traumatic experiences (van der Kolk, 2003). If a child becomes overwhelmed and doesn’t want to move, the therapist can simply mirror the child’s position, to give them the message that he or she is not alone during this
painful and confusing time (Spitzer, 1990).

Directive movement and other structured activities are used in DMT to help decrease anxiety (Kornblum & Halsten, 2006). Therapists can also use humor in therapy to reduce anxiety and connect with difficult children in the group (Kornblum & Halsten, 2006). Humor can be a cathartic release and provide a break from working through difficult topics related to abuse. Specific therapeutic structures suggested by Kornblum and Halsten (2006) to work with anxiety include: 1) use movement to express feelings while disclosing or as response to disclosure, 2) slow down the sharing process by reminding the children about confidentiality and doing a check-in on how members are feeling, 3) use relaxation and grounding techniques (abdominal breathing, rhythmic movement), and 4) develop movement-based therapeutic stories that can be used as a metaphor to help work through intense feelings. Directive movement and other structured activities help children to feel contained, supported by the therapist, and more in control. When a child can feel such experiences, his or her overwhelming anxiety can be overridden.

Treatment category 4: Sexual abuse during childhood severely disrupts a child’s opportunity to engage in childlike activities. Children become so preoccupied with keeping safe that they miss chances to play and use their imagination to interact with the outside world. Sexually abused children are constantly trying to survive physically as well as psychologically.

Therapeutic interventions:

The body is the first place a person learns to be creative and the use of spontaneous movement improvisation can “reconnect the individual with his or her creative impulses” (Callaghan, 1991, p.158). Based on this understanding, the emphasis in DMT on the body and the use of improvisation provides a unique
treatment for sexually abused children. In DMT, therapeutic structures are used that require the use of creativity, for example encouraging movement improvisation and experimentation with moving in different ways using different body parts (Frank, 1997). Improvisation would usually be too overwhelming in the beginning phase, but can now be a successful therapeutic structure to address the issues in this category. It is important to encourage sexually abused children to employ their creativity and imagination that was probably repressed during their traumatic experiences.

In all three phases of this clinical model, opportunities need to be provided that allow sexually abused children to engage in childlike activities such as playing, using their imagination, and being creative. Since these children often have difficulty playing or show restricted, rigid, and repetitive play, they need to learn how to expand their playing abilities and feel comfortable while playing. This process takes time as children who have been sexually abused have had to focus on reality to try and be in control to stay safe. To play they have to disconnect from reality, and pretend and imagine, a process that feels unsafe and uncontrollable similar to their traumatic experiences (Streeck-Fischer & van der Kolk, 2000). To help sexually abused children to be able to enjoy playing they need to learn that focusing on something outside of reality is not always related to traumatic uncontrollable experiences but can actually be enjoyable. This type of activity helps children to observe before reacting, learn from new experiences, and work through their trauma without becoming immediately disorganized (Streeck-Fischer & van der Kolk, 2000). These issues are addressed in DMT by helping children learn to expand their movement repertoire, such as with improvisation, which gives them more options of
how to play and interact. By assisting children to be comfortable being creative, playful, and imaginative the therapist addresses a common cognitive issue of these abused children’s inability to be flexible and creative in problem-solving tasks. Engaging in imaginative play and being creative can in itself be healing. It provides children with a feeling of happiness, a sense of freedom to be themselves, and many other experiences and feelings that are a natural part of a healthy childhood.

Dance/movement therapists have unique techniques that allow children to engage in creative activities while working through the issues of their traumatic experiences at the same time. Dance and improvisational movement create ways to work through trauma such as abuse on the poetic level (playful, creative exploration of new ways of being) and cathartic level (working through emotional trauma without freezing/collapsing in defense) (Lumsden, 2006). Dance/movement therapists use creative movement tasks and imagery to expand a child’s awareness and creativity to help them communicate about frightening thoughts and emotions (Goodill, 1987). These methods can make communication about the abuse easier as they provide children with structure and tools to contain their thoughts and emotions. These methods make them feel safer and less vulnerable to becoming re-traumatized. Due to the difficult nature of these children’s thoughts and emotions, it is important that the therapist makes it as easy as possible for them to express their feelings or otherwise this process may not happen at all.

_Treatment category 2:_ Sexually abused children have difficulty expressing their emotions. They may be either unable to control their emotions or they have the need to over-control them. Their memories associated with abuse contain specific sensations, sounds, and images. If these sensations are triggered, they easily cause flight or fight reactions.
Therapeutic interventions:

In the middle phase, the therapist continues to encourage children to use movement as a non-verbal form of emotional expression. For example, a dance/movement therapist may ask the children in a group to express how they are feeling with movements instead of words. Metaphors, life narratives, movement stories, and imagery are used in DMT to help children feel more comfortable expressing their feelings (Kornblum & Halsten, 2006; LeMessurier & Loman, 2008). Therapists need to accept that sometimes there are emotions and experiences that children can not express in words and so DMT methods simply give the child a different way to express themselves. Ultimately, it is more important that children are able to express their feelings than how they choose to express them.

The understanding that school aged children have begun to differentiate between themselves and their parents and understand that they have a separate reality supports many emotional developments at this stage (Cincotta, 2002). Therefore, it appears that therapy on emotional expression can be particularly successful with this age group. It is possible that therapeutic intervention at this age helps children develop needed skills in this area at the point when they would normally be developing these skills instead of needing to treat issues later on that developed from not having such skills. At this time in the therapy process, if the children are ready, the therapist begins to address issues of this treatment category on a different level. The children learn to express emotions and emotional memories that are directly related to their abuse experiences and expand the range of their experiences. Since these children often have affect regulation issues, making it difficult to express their feelings safely
and in a controlled manner, it is important that they are given structures that allow them to practice the necessary skills to do this. Props are used in DMT as a vehicle for expression of emotions and memories in a safe and contained way. Balls and pillows are props used to release or express feelings of aggression directed towards an abuser(s) (Frank, 1997) or non-abusing people who were involved in the abusive experiences. This release and expression of feelings of aggression would not have successfully worked if used in the beginning phase due to the limited coping skills and lack of trust for these children. It is important that the therapist helps children recognize and reflect on their abuse-specific attributions such as feelings of blame and aggression concerning their abuser (Feiring & Cleland, 2007). Children can become aware of the body level warnings that they feel when an emotional memory is triggered and they want to take action or run away. Once they are able to recognize these bodily warnings, they can learn to use their new coping skills to target them. The therapist can use a structure called tracking where they ask children questions about their internal feelings to help make them aware of these feelings and keep the children in the present while they are working through the issues of this category (Kornblum & Halsten, 2006). To help them have a more full experience and reduce their need to control what they experience, the children are encouraged to explore themes, and label their experiences in therapy (LeMessurier & Loman, 2008).

Treatment category 5: Sexually abused children often lack certain developmental skills or have interruption and damage in their development. They may form unhealthy attachment patterns or not develop a secure sense of self or identity.

Therapeutic interventions:

The emphasis in DMT on movement and the body provide advantages for working on developmental issues caused by sexual abuse. Dance/movement therapy
can easily help children return to an earlier stage of development because it naturally supports this exploration as part of the therapy process. It is now safer to do this instead of in the beginning phase because the children have developed coping skills and trust the therapist and group to support them in this process. Infants and young children experience the world and communicate by using their bodies and movement because they don’t have verbal abilities (Weltman, 1986). Therefore it follows that children and adults can develop or re-learn skills linked to these stages of development, using the body and movement as tools. In addition, the Kestenberg Movement Profile (KMP) is used in DMT to provide a guide for therapists to help children progress through developmental areas, on a movement level, to acquire skills that they never had or were damaged due to abuse. An example of a therapeutic structure, described by Weltman (1986), that allows the child to feel like a small child is having a child use self-directed movement with a cloth. The child is wrapped up in a cloth and is then rocked and rolled to provide nurturing and reinforcement of body boundaries. The therapist moves together with them to support them on a movement level.

This therapeutic structure also stimulates integration and mastery of trauma-related bodily sensations and emotions. The children learn to safely experience different physical sensations and feel comfortable exploring their environment instead of remaining numb and isolated (Streeck-Fischer & van der Kolk, 2000). Perry’s (2006) neurological theories support the use of the body and movement to address developmental issues. Perry demonstrates that specific developmental issues on the neurological level, such as dysregulation, can be addressed by using patterned,
repetitive sensory input such as dance, drumming, music, and massage. It is believed that this input can positively affect brainstem neurobiology to reduce dysregulation that can encourage the child to not feel the need to stay numb and isolated. In order for these positive changes to occur on this basic neurological level, that is connected to all other levels, these experiences must be repeated many times (Perry, 2006).

Dance/movement therapists provide therapeutic structures to expand a child’s movement repertoire and increase his or her self awareness by using different ways of moving, witnessing others move, and being witnessed in a safe structured format. The use of DMT techniques allows the therapist to help children go back to earlier developmental stages that may be pre-verbal, to gain in skills (Loman, 1998). Movement is a powerful and creative mode of healing that helps children reconnect with their core self and work through problems non-verbally and build new pathways for healthy development (LeMessurier & Loman, 2008). When skills that children naturally learn in pre-verbal stages don’t develop or are lost, it becomes much more difficult to verbally teach them these skills. In DMT, therapists use therapeutic structures that require the use of certain skills common to earlier stages of development to give children exposure to these experiences.

Attachment issues continue to be addressed in the middle phase by practicing different movement rhythms and patterns, and using mirroring and dancing to help the child re-choreograph early attachment issues and progress to a higher developmental level. Opportunities to move together with the therapist and other group members allows for development of attachment and bonding (LeMessurier & Loman, 2008) to eliminate unhealthy attachment patterns. Group DMT experiences
help children create healthy attachments with other group members that can aid them in developing healthier relationships and interaction styles in and outside of therapy.

Some issues that arise when a school aged child is not able to develop healthy relationships and attachments, are related to issues concerning changes in his or her identity and sense of self that are normally strengthened during this developmental stage. Healthy school aged children are inquisitive and always want to know more about everything. They start to think more autonomously, assert their independence, and establish themselves as unique individuals. Also, school aged children experience physical changes that cause them to feel stronger and more capable of doing various tasks (Cincotta, 2002) that also support the development of their identity and sense of self. In DMT, the creative process of movement can be used to help children explore and learn about their identity and sense of self. An example is to have each child create a movement phrase or story that communicates something about themselves to the group. Using movement to express themselves is often easier for them as it is a child’s natural form of communication and expression (Weltman, 1986). Since movement is familiar to all ages, it is an easier tool to use for expression and self-discovery. As sexually abused children become more aware of their identity and develop a stronger sense of self, it is important that they work to integrate or reintegrate of all parts of the self. Dance/movement therapy is a complex therapy that incorporates the body, emotional and aesthetic expression, social interaction, symbol, and metaphor (Lumsden, 2006), which makes it a unique therapy to address issues of integration and reintegation for abused children.
Later in the middle phase, the therapist will need to help the children use their more integrated self to become assertive and independent. Teaching abused children a broader range of movement Effort possibilities will give them more choices when, or if, they are threatened with abuse in the future. Specifically, dance/movement therapists help children to use strength in the lower half of their bodies and move in space through the vertical plane. These movement qualities are associated with stability and confrontation, and will aid in their development of a sense of personal power and independence (Goodill, 1987). A specific therapeutic structure, presented by Goodill (1987), to elicit these movement qualities is for the therapist to have the children follow them as they do movement sequences that have assertive qualities such as power, strength, bravery, and persistence. The children are then encouraged to move around the room using these new qualities they just experienced. This gives the children a chance to play with how it feels to be assertive and how they personally express it. The terms and explanation of assertive qualities may need to be altered depending on the level of understanding possible for the specific group of children. Even if the children don’t completely understand the concept of this therapeutic structure, they will be able to learn to take the movement qualities in on a body level.

*Treatment category 1:* Sexual abuse is a negative experience that directly involves and damages a child’s body, physically and psychologically. Sexually abused children often develop body level issues such as dissociation, somatic issues, negative body image, and negative body/somatic memories.

Therapeutic interventions:

The physical and psychological issues in this treatment category can be addressed more directly and on a deeper level than they were in the beginning phase. The dance/movement therapist continues to help the children increase their body
awareness in addition to encouraging them to reconnect with their bodies. Some current neuroscience literature indicates that treatment should increase awareness of internal somatic states. This deeper understanding allows children to react realistically to somatic sensations instead of always reacting as if they are re-experiencing previous trauma. This ability is important for children to manage problems and experiences instead of just reacting reflexively (van der Kolk, 2002).

The related issues of body boundaries and personal space also need to be worked through on a deeper level in the middle phase. Exploring different types of boundaries through working with kinesphere, and shaping (LeMessurier, 1990), dance/movement therapists help children strengthen their body boundaries and gain a better sense of their personal space. Dance/movement therapy creates concrete experiences of body awareness and personal and interactional space to restore integrity on a body level at the body core. As the children become more connected to their bodies and their personal space, therapists work to help the children feel more grounded and connected that brings a shift of power and control that can empower the children (Weltman, 1986). Children learn on a body level that they can be strong and have the right to protect their bodies and their personal space that was violated when being abused. These types of interventions have been found to reawaken parts of the body that were cut off or made numb in response to the abuse when used in DMT work with adult survivors of sexual abuse (Punger, 2000). Since the literature indicates that children as well as adults who have been sexually abused respond on a body level in much the same way, it is reasonable to speculate that children could also benefit in the same areas from these interventions. There is a specific therapeutic
structure created by Kornblum (2002) that helps children have a better sense of their personal space and practice being in control of that space. Children in the group are divided into pairs and face each other with a large distance between them. A partner starts taking steps towards the other partner, who remains still, until they are told to stop moving by the partner because they are getting too close to them. Everyone then looks at the other sets of partners to recognize that it is natural for everyone to have a different amount of space that is comfortable for them. Finally, the partner’s roles are switched and the structure is repeated.

Issues concerning touch can be more safely addressed in the middle phase when the children have developed a sense of trust in the therapist and a feeling of safety in the group. Dance/movement therapists help the group members learn about safe touch to recreate a sense of control and ownership over their bodies and personal space (Goodill, 1987). Dance/movement therapists carefully choose a variety of therapeutic structures that allow for safe, structured, and playful touching to help increase their connection with their body and to emphasize to the children that there are safe people and there is safe touch (Goodill, 1987). The therapist must continually remind children that they always have the right to say no to any kind of touch, even when it is in the therapy environment, to reinforce that they are always in control of their bodies and have the right to protect them. The hope is that eventually the sexually abused child will feel safe being touched and perhaps gain some pleasure and healing from such touch. While being abused, children had no control over what happened to their bodies and touch was part of the abuse. Getting these children to be
able to defend their bodies and personal space in addition to feeling comfortable with safe touch will take a great deal of time.

Dance/movement therapy provides repeated opportunities for a child to experience joy while using the body and experiencing body sensations. Hopefully, this repetition can eventually override negative and painful associations that occurred on a neurological level in his or her body. Body level issues are complicated and they are particularly confusing for people who have been abused and may have cut themselves off from their bodies completely. Although school aged children have less cognitive understanding of their bodies than adolescents or adults, they are beginning to increase these skills during this stage of development (Cincotta, 2002). It is important to consider that sexually abused children may either have less cognitive skills due to the abuse or may actually appear more mature in their level of understanding of certain things for the same reason. Dance/movement therapy provides concrete ways to work through body issues that can make the process easier for children than verbal explanations. In DMT, school aged children are able to experience body level issues through their bodies and perhaps gain understanding on a subconscious and/or neurological level that may not be possible through other therapy methods.

In addition to increasing body awareness and reconnecting with the body, DMT can be used to treat physical body attitude issues, movement issues, and physical issues in this population. Dance/movement therapists believe that by exaggerating and/or intensifying a movement or posture, recuperative movement in the opposite direction is encouraged and allows for the release of held patterns (Kornblum &
Halsten, 2006). These non-verbal techniques allow the dance/movement therapist to help children with these issues regardless of how much they understand about their unhealthy movement patterns. Even older school aged children may not understand these concepts, which make the DMT techniques particularly useful. In therapy children are supported and encouraged to move in new and varied ways that expands their movement repertoire and moves them towards becoming healthier.

Another important area to address in this category is the negative feelings and attitudes that abused children may have towards their bodies and movements. These feelings and attitudes may be more significant in older school aged children as described in DMT work with adult survivors of childhood sexual abuse (Valentine, 2007). These feelings and attitudes are often reflected in a negative body image and can be dealt with directly by helping children make connections between their abusive experiences and the feelings and attitudes they have towards their bodies. Making these connections can be difficult, but it will help them to reduce the control that these experiences have on their lives and their view of their bodies. A therapeutic structure suggested by Frank (1997) that combines different therapy methods, that is used for adult survivors and adapted for use with children, is to have children draw an outline of their bodies with chalk on the floor. Once this is done they color: 1) the parts of their bodies that are strong, 2) parts they dislike, 3) parts they are proud of, and 4) parts that produce shame. The therapist should make observations about how large or small the children drew themselves (Frank, 1997). If a child doesn’t want to draw his or her body or is having trouble doing so, the therapist can assist. Next the therapist has a few different options depending on how
the group responded to this activity. They may have the children move freely around the room first using body parts they consider strong or in which they have pride, and then do the same with body parts that they dislike or that produces shame. The children can also come up with a single movement or a phrase to express how they feel about their body parts, or to non-verbally describe the qualities of a specific part. The group can also talk about the different parts that they colored and why they feel the way they do towards these parts.

Since traumatic memories are held in the body, they can also be healed through the body using movement and play to address areas of treatment in an integrated way (LeMessurier & Loman, 2008). In the middle phase, the therapist can start addressing a child’s body/somatic memories. Sometimes these traumatic memories are comprised of body sensations with little cognitive processing that makes it difficult for the child to make sense of the memories (Rothschild, 2002). Dance/movement therapy provides a variety of ways for children to work through these memories. The ability of a child to work through and understand these body/somatic memories will differ depending on the individual child and his or her past abusive experiences. In general, the memory development that occurs when children are approximately 6 to 11-years-old allows them to recall sequences of events in the present and the recent past. Their developing ability to use language as a cognitive skill causes changes in memory functioning and they begin to realize that they can both remember and forget their experiences (Cincotta, 2002). These developing skills aid in the process of working through body/somatic memories with school aged children, although these memories are a unique type of memory. The therapist has to be careful to work
through these issues at a pace set by the child and to not make any suggestive
questions or comments that may influence the process. Movement allows the child to
work through these memories on a non-verbal and sometimes less direct level.
However, having children use their bodies to access these memories that are stored in
the body can in fact be more direct. Accessing memories through the body can occur
quicker than verbal therapy and be disturbing to the child so the therapist needs to be
careful that he or she is not overwhelmed (Callaghan, 1993). As with all aspects of
the middle phase, working directly through abuse related material always takes a
great deal of time and can never be rushed. That is part of the reason why this
clinical model is long term and why each of the three phases can be as long as a group
of children needs it to be.

*Treatment category 6:* Although sexual abuse is clearly the fault of the perpetrator,
abused children often feel shameful and dirty about the experience. They feel guilty
because they did not stop or disclose the abuse earlier. These feelings and negative
cognitions damage self-esteem, and can lead to depression, and suicidal thoughts and
behaviors.

**Therapeutic interventions:**

To build physical health and work deeply on the issues of shame, guilt, and
damaged self esteem in this category, the therapist must try to acknowledge the
positive, intact, and healthy parts of the child instead of his or her negative aspects
(Kornblum & Halsten, 2006). Often children are referred to treatment because of
their negative behaviors and other issues, and they are usually very aware of these
parts of themselves. It is this knowledge that can perpetuate their negative
cognitions, low self-esteem, depression, and suicidal thoughts and behaviors. To
address these issues the therapist needs to give children an opportunity to express
their feelings and thoughts about: their abuse experiences, others people’s reactions to their disclosure of the abuse, and the events that occurred after they disclosed. Children should also be given a chance to talk or otherwise express how they feel about themselves. Their feelings and thoughts can be expressed through movement and movement narratives. These non-verbal techniques of DMT can provide a way for children who are not able to talk about these feelings, even at this point in therapy, a way to express, release, and work through feelings rather then repressing them.

Dance/movement therapists try to make empathetic connections between themselves and the client to allow the child to take on some of the therapist’s ego strength and self-esteem (Punger, 2000). Empathetic connections give a non-verbal message that the therapist accepts the child as he or she is and believes the child is an important person. These connections can be made using mirroring, follow the leader, and free movement where the child moves and the therapist reflects the quality of his or her movements. The dance/movement therapist needs to use these techniques with caution as they could be overwhelming for children and remind them of the connections their abuser(s) tried to make with them. Using movement to express oneself freely can also improve self-esteem (LeMessurier, 1990). The ego strength and positive self-esteem of a child can be increased by improving his or her ability to use strong weight (Wegrzyn, 1993) and increasing his or her use of the vertical plane (up and down). In DMT, it is believed that changing people’s physical body attitude that is observed in the way they hold their bodies when they sit, walk, and do other tasks, can also be beneficial to their self-esteem. For example, a sexually abused child that is depressed may often hold his or her chest and shoulders tensely in a
concave position, cutting themselves off from interactions and exploration.
Therapists can guide the child be able to open up his or her chest, expand out and
reach towards others, and release muscle tension.

The process of being involved in DMT can provide positive and rewarding
experiences that establish and/or reinforce positive qualities in each child, reflect his
or her value to the group, and help them to become more aware of these qualities in
themselves. Children can express on a non-verbal level their acceptance of others by
following the movements of their peers in structures such as follow the leader or
mirroring. If it appears that the children in the group can be respectful, let them talk
about positive experiences and interactions they have had either with the whole group
or with a particular group member.

Treatment category 8: Abused children may strongly avoid remembering their painful
and overwhelming experiences. Children may however, have intrusive thoughts, relive
traumatic memories, or unconsciously reenact a traumatic incident physically. In therapy,
these children commonly do not remember, or can not verbalize, their experiences.

Therapeutic interventions:

This therapeutic category was not addressed in the beginning phase due to its
intense and overwhelming nature. The issues in this category take a great deal of
effort and time to work through and require that the therapist be cautious in their
approach. Despite the challenge that is presented, working through the child’s
traumatic abuse experiences is an essential part of his or her healing. Sexually abused
children need to have a chance to express and understand what happened to them.
They also need to learn to feel in control of their physical and emotional reactions
tore act to current situations appropriately instead of recreating their traumatic
experiences by impulsively reacting to protect themselves (van der Kolk, 2003).
Dance and improvisational movement are used to as ways to work through trauma on the poetic and cathartic levels. It is essential that the therapist help the child to heal these aspects of the self (Lumsden, 2006) and process and incorporate his or her traumatic experiences while not making them feel traumatized all over again (van der Kolk, 2002). As a client, adult or child, begins to re-experience his or her traumatic experiences on a physical and emotional level, the therapist can work to make sure that he or she does not become re-traumatized. This is done by keeping all of their physical experiences in therapy or memories of such experiences connected and attributed to the here and now or recognized as occurring in the past that they survived (MacDonald, 2004).

When traumatized children are given the chance to build long-term therapeutic relationships they can hopefully work through more specific aspects of the trauma through movement re-enactment and re-choreography (LeMessurier & Loman, 2008). Dance/movement therapists help the children feel safe by giving the verbal message that it is okay to talk about sexual abuse while also giving the non-verbal message that they will be accepted and their feelings will be contained (Weltman, 1986). The opportunity to share unconscious thoughts and terrifying experiences with someone else, without losing their support, helps these children to feel some relief from the burden of having to keep such a secret (Wegrzyn, 1993).

Although working through abuse experiences is a difficult task, DMT with its use of the creative process, provides many unique ways for a child to carry out this task. The creative methods that DMT provides allow the child to be in control of the process of working through his or her traumatic experiences instead of being invaded
by intrusive thoughts or memories and reenacting traumatic incidents. These methods also protect against the risk of damaging the therapeutic relationship with the therapist that occurs when these children are asked the same questions repeatedly to get information about their experiences (Henry, 1997). Sexually abused children can tell stories about their feelings or connect memories, dreams and events more easily either symbolically or literally through movement, play, or mime (Goodill, 1987). Therapeutic structures such as creating a movement story or personal movement narrative can be a way for children to work through and more deeply express what they have experienced to the rest of the group. They are working through their experiences on both a cognitive level to create a story, and on a body level by involving their bodies in the process. The non-verbal emphasis in DMT helps these children to express their memories about abusive experiences that may be too painful, confusing, or developed at a preverbal stage (Goodill, 1987). Non-verbal techniques can also help the therapist to break down the process of working through their abuse experiences into easier and less direct parts. It is important that children tell the story of their abuse in their own way and in their own time. When children are forced to repeatedly repeat their abuse experiences it can connect them with painful memories that have the potential to reinforce the internalization of guilt and shame created by the sexual abuse (Henry, 1997).

5.7.3 Ending phase

This clinical model uses a long-term format with no set number of sessions for any of the three phases or the model as a whole. Therefore, similar to the middle phase, the therapist initiates this ending phase when individual members, and the group as a
whole, appear ready to move towards termination. Similar to preparation for transition between the beginning and middle phases, the therapist must again make assessments of each child’s level of readiness to end therapy. It is difficult to describe how to assess whether a child is ready for termination as each child’s traumatic experiences, issues to work through, and comfort with therapy approaches is different. Indications that a child or a group is ready for termination will differ between groups but may include: 1) questions from members about when therapy will end, 2) children showing an interest in planning activities for the final therapy session, and 3) indications of a certain level of mastery of skills and abilities that are important for healthy functioning in life beyond therapy. As in the middle phase, not all children in the group will be ready to end therapy at the same time. Some children may appear ready to end therapy earlier than expected and the therapist will have to be creative to keep them engaged until the last session. Other children may appear to need continued therapy beyond the end of this group to completely work through their issues and address feelings about terminating group therapy before they feel ready. Ultimately, the therapist needs to provide sufficient time for each child to develop important life skills and work through his or her issues and past traumatic experiences. The therapist will make the decision to either continue therapy for the whole group until each person is ready to terminate or choose to end the group and provide continuing treatment for children that need more time.

Since many abused children have experienced losses in their lives, it is important to deal with termination properly and give children enough time for this process. All the children need to have the chance to say goodbye to other group members and the therapist. The therapist should use this phase to help children feel confident enough in
their new skills and abilities to use them once therapy has ended. The ability of school-aged children to become skilled learners by contributing what they know to the performance of new tasks (Newman & Newman, 2006), will help them successfully combine the new skills and abilities they gained in therapy. When therapy is nearing the end it is important for the therapist to limit introduction of new or intense information and issues. The group members need this time to review and assimilate their experiences as much as possible.

As was presented in the beginning and middle phases, the description of the ending phase contains treatment categories that should be addressed and suggests DMT therapeutic interventions that contain concepts and therapeutic structures as exemplar for these categories and associated effects. Ultimately, the issues addressed in each treatment category in the ending phase depend greatly on the work that was either accomplished earlier or is ongoing from the beginning and middle phases. As has been true throughout this model, the interventions will differ for each group of children.

Treatment category 8: Abused children may strongly avoid remembering their painful and overwhelming experiences. Children may however, have intrusive thoughts, relive traumatic memories, or unconsciously reenact a traumatic incident physically. In therapy, these children commonly do not remember, or can not verbalize, their experiences.

Therapeutic interventions:

Working through traumatic experiences takes a long time because these experiences cause children to develop strong defenses just to survive and avoid remembering their abuse. Therefore, the greatest emphasis should be placed on this category in the remaining time available. Some children will need more time, perhaps in individual therapy, to fully work through all of their traumatic experiences. The therapeutic structures from the middle phase used to address this category can be
repeated, and the therapist can make alterations depending on the needs of the group members. The therapist should try to continually encourage the children to work through their traumatic experiences, validating that it is difficult, and praising them for the work they have already done. Since some children will need more time after this treatment has ended, it will be important that the therapist either continues to provide therapy for them or makes sure that they are connected with other services as well as their families. Since this clinical model is meant to be used as part of a multi-disciplinary treatment program, it is the hope that other services will be readily available to these children.

A new therapeutic structure described by Goodill (2008) that is effective at crystallizing the process of therapy as a whole, and this treatment category specifically is called the journey. Each child is asked to start on one side of the therapy room and move to the other side in any way he or she would like. They are told to make their path represent the journey they have made through their whole time in therapy working on their abuse experiences and stop when they reach the point where they are now. When everyone has reached the place they feel they are in their journey, which doesn’t have to be a completed journey, the therapist talks to the group about what they observed about all of the children’s journeys. The directions and activity as a whole may need to be modified depending on the abilities of the specific group of children.

Treatment category I: Sexual abuse is a negative experience that directly involves and damages a child’s body, physically and psychologically. Sexually abused children often develop body level issues such as dissociation, somatic issues, negative body image, and negative body/somatic memories.

Therapeutic interventions:
The issues of bodily damage in this treatment category represent a large portion of the issues seen in sexually abused children. These issues are deep seeded and often difficult to understand and therefore take a long time to address completely. In the ending phase, the therapist should continue to work on all body level issues, either by repeating previous structures from other phases in this category or making changes in these structures to best meet the current needs of the group members. It is the ultimate goal of the therapist to strengthen the positive and healthy skills and attitudes that the children have developed towards their bodies to help them to continue to see their bodies in this new way. Specifically, issues associated with touch are challenging to work through and take a time and patience to address fully.

Depending on the children in a particular therapy group, activities presented in earlier phases to address touch may need to be either postponed until this phase or may still need work in more direct and challenging ways to meet the children’s needs.

**Treatment category 6:** Although sexual abuse is clearly the fault of the perpetrator, abused children often feel shameful and dirty about the experience. They feel guilty because they did not stop or disclose the abuse earlier. These feelings and negative cognitions damage self-esteem, and can lead to depression, and suicidal thoughts and behaviors.

**Therapeutic interventions:**

Therapeutic structures used to work on feelings of shame and guilt, and improve self esteem in earlier phases can be repeated or adjusted and continued in the ending phase. In this phase, therapeutic structures can be used that synthesize the positive qualities each child has learned about themselves as a unique individual. Movement sequences or other structures can become transitional objects that will help the children make the transition out of therapy. For example, each member can create a
movement phrase that shows the rest of the group some positive qualities about
themselves and/or aspects they will remember about the therapy experience. These
phrases may include actions that they learned that they are good at doing physically
or movements and pantomime to indicate personal qualities they have discovered
about themselves. The children can also create written lists of positive traits that they
now possess or create some artwork to reflect qualities about themselves. The
therapist can describe verbally or non-verbally their experiences being in the group,
and the positive changes they have seen in the children. To ensure that the children
feel safe, the therapist should talk in general terms instead of singling out particular
group members.

*Treatment category 5:* Sexually abused children often lack certain developmental skills
or have interruption and damage in their development. They may form unhealthy
attachment patterns or not develop a secure sense of self or identity.

*Therapeutic interventions:*

During the ending phase in terms of this treatment category, it is important to
focus on helping the group members to practice and eventually integrate new
developmental skills learned in earlier sessions so these skills become part of their
permanent repertoire. This repetition is more important than either trying to teach
them new skills or going deeper into their issues at this point in therapy. Hopefully,
this repetition will continue to help the children integrate and use their new
developmental skills.

As part of this phase the therapist should also continue to help the children
integrate all parts of themselves; cognitive, emotional, physical, and interpersonal.
Having all parts of the self integrated into one and having a sense of self/identity, will
aid these children in the transition from therapy to their world and future outside of therapy. The therapist can provide structures that require the children to practice and integrate their many new skills so that they can begin to understand how they are related. For example, the group juggle game previously described in the beginning phase under treatment category 7 is a good activity that requires the use of their cognitive, physical, and interpersonal skills.

_Treatment category 7:_ Sexually abused children often develop problems with relationships, social skills, and social interactions with other children and adults. They learn that they can not trust some adults. Abused children can develop age or socially inappropriate behaviors, for example precocious sexual behavior, that disrupts social interactions and leads to social isolation.

Therapeutic interventions:

The social and interpersonal skills learned in this category during previous phases are essential to many aspects of a child’s life. It is important that these new skills are reviewed to help the children understand how to use them outside of therapy. It can be effective to repeat previously used cooperative games to practice social and interactional skills and to maintain the group cohesiveness that will provide support as therapy ends. Children’s comfort and familiarity with these games can give them room to focus on practicing specific skills and being part of the group, rather than figuring out the game or worrying about if they will be successful. A therapeutic structure suggested by Meekums (2000) that is useful in this ending phase is called the web. Sitting or standing as a group, a ball of brightly colored yarn is tossed from person to person as they share something that they remember about their time together as a group. Each person holds on to the yarn as he or she tosses it to the next person creating a web. This game is continued until everyone has gotten the ball and
had a chance to speak. As always a child can choose to just hold onto the string and pass it without saying anything. The structure of the web provides each child with the chance to participate and be connected to the group even if it is too difficult for them to verbalize his or her experiences. The end product is a web that symbolizes the connections they have made with all members of the group. Another fun structure is to reverse the process so that the string is wound up and finishes with the first person (Meekums, 2000).

**Treatment category 4:** Sexual abuse during childhood severely disrupts a child’s opportunities to engage in childlike activities. Children become so preoccupied with keeping safe that they miss chances to play and use their imagination to interact with the outside world. Sexually abused children are constantly trying to survive physically as well as psychologically.

**Therapeutic interventions:**

This treatment category is addressed in the ending phase by the therapist continuing to provide the group with opportunities to engage in childlike, creative, and joyful activities. Children need to transfer the benefits of therapy to their life as a whole as therapy is ending. Therapists can ask the children what they like about these types of therapeutic structures and have them suggest other similar activities that could be done outside of therapy. Themes related to termination and saying goodbye can be incorporated into childlike activities to address these difficult topics in a fun, creative, and less intense way. A suggested therapeutic structure is to have the group create a movement narrative or phrase/dance together that represents their experiences as a group. This narrative or phrase can be repeated throughout the ending phase and can serve as a transitional object for the children as they leave therapy.
Treatment category 2: Sexually abused children have difficulty expressing their emotions. They may be either unable to control their emotions or they have the need to over-control them. Their memories associated with abuse contain specific sensations, sounds, and images. If these sensations are triggered, they easily cause flight or fight reactions.

Therapeutic interventions:

In the ending phase the therapist should help the children practice techniques for emotional expression and other related skills that were learned in the other two phases. A sign that the therapy methods were successful is if the children are able to apply what they learned in therapy to real life situations. Activities for this treatment category in earlier phases can be repeated and altered to make them more challenging for the group. The therapist can start this phase by reviewing the past activities and skills learned to see what the children remember and detect areas that need more practice. Since termination is an emotional experience, the children need an opportunity to express their emotions and talk about their group experiences. For the children to be prepared for this emotional time they need to know in advance when the therapy will end. Some therapeutic examples to address emotions related to termination include: 1) ask the children what they think they learned from being in this group, 2) what they will remember when they leave, and 3) what they liked and disliked about the therapy experience. The children can also choose a movement or movement phrase to express their answers to these questions and how they feel about ending the group and saying goodbye. These phrases can be combined into a group phrase as a form of closure, or the movement narrative or phrase/dance that was created as a group in treatment category 4 of this phase can be repeated at this time.

Treatment category 3: Abusive, traumatizing experiences that children can not control can be terrifying, confusing, and painful. Abuse can cause strong feelings of fear and
high levels of anxiety that make children susceptible to hyper-arousal or becoming overwhelmed physically and emotionally. These issues affect various aspects of a child’s life and create challenges for therapists working with them.

Therapeutic interventions:

As was done in the beginning and middle phases, in this phase the therapist needs to continue to set boundaries of space and time for the group. This will be more important as the children work on the emotional issues of termination in this phase. The specific issues of this category such as high anxiety, hyper-arousal, and feelings of not being in control, will be stimulated and the therapist needs to approach termination and saying goodbye with extreme caution. Although these children have practiced coping skills, learned to feel more in control, and learned to trust the group and the therapist, they can still become overwhelmed by the intense feelings related to termination. The reason they may feel overwhelmed is because they do not have control over ending the therapy and having to say goodbye that reminds them of being out of control when they were abused.

It is important to continue to help increase each group member’s sense of safety and control (Kornblum & Halsten, 2006). As before, the therapist should stress the importance of keeping the group experiences confidential even after the therapy ends. To reduce anxiety and the feeling of being overwhelmed, the therapist should give the group enough warning about when the final therapy session will occur. About 4-6 weeks before therapy will end it can be helpful to create a way for the children to visually count down to the last session to understand how many sessions remain. Calendars can be made and days crossed off each time the group meets, or boxes can be drawn on paper to represent each day left that children can cross off or decorate to
symbolize the completion of a session (Wegrzyn, 1993). In the final therapy session, the therapist needs to remind all group members that it is natural for each person to deal with saying goodbye differently. In this final session each child can choose how he or she wants to say goodbye to the group; verbally, non-verbally, or not at all. This structure provides a final feeling of closure and gives the children the chance to be able to say goodbye that they may have not had in previous experiences.

5.8 DMT Clinical Model: Model Summary

This is a working model that is designed to be long term with specific categories and a selected order of these categories to address the needs of this population. This model can be adapted for short term use by selecting a subset of categories in each phase and only implementing specific therapeutic structures. Ultimately the therapist working with a specific group of children must decide on the treatment that best meets the individual or group needs. An overall summary of this DMT clinical model is presented as a reference for making selections of treatment options (see Table 4). Regardless of the available time frame, or treatment structures selected from this clinical model, there should be three fundamental elements in all therapy with sexually abused children: 1) create a safe, supportive environment, 2) work to develop a healthy therapeutic relationships between the children and therapist, and 3) teach coping and other needed skills to keep the child safe and more successful in his or her daily life. Treatment category 3 in the model should be included as it specifically addresses how to help these children experience how it feels to be safe, believe that they have the right to safety, and be equipped with skills that will allow them to take care of themselves or get help from others when they need it. Since all eight treatment categories are important, if time is
limited it would be most beneficial to address all categories on a basic level rather than addressing a few categories more deeply. Therapists using this model need to be realistic about what can be accomplished within the time allotted for treatment. It is not beneficial for the therapist to push the process too quickly simply because time is limited. Therapists need to assess the readiness of all group members to move onto a new treatment category or therapeutic structure.

Another recommendation for implementation of this clinical model within a limited time frame is to find ways to combine treatment efforts to address more than one treatment category with the same therapeutic structure. For example, treatment category 2 and 6 can both be addressed though helping the children learn to express their emotions, specifically targeting expressing their feelings of guilt, shame, and other negative feelings about themselves as a person. In addition, some therapeutic structures can be used to combine the goals of more than one treatment category. Creative movement tasks is a therapeutic structure that addresses multiple categories by helping children to: 1) move in new ways, 2) explore freely to learn about themselves, 3) learn to be creative and imaginative, 4) express their thoughts and emotions, and 5) become aware and connected to their bodies in a positive way. These are just a few examples that will hopefully give therapists using this clinical model, ideas of how to combine categories and use therapeutic structures to address numerous goals.

5.9 DMT Clinical Model: An Update

This updated DMT clinical model is based on the goals and techniques presented in foundational and recent DMT literature that address therapy with sexually abused and otherwise traumatized children. When the foundational DMT treatment models for
abused children were written there was less information available to aid the design and implementation of treatment. This model updates foundational DMT work by incorporating recent and foundational literature, concerning DMT with adult and child victims of trauma or childhood sexual abuse, into a comprehensive representation of this therapeutic work. This DMT clinical model integrates the effects, treatments and concerns presented in the literature for other forms of treatment to find all connections between DMT and other forms of therapy for this population. This clinical model updates earlier DMT work by highlighting how DMT can effectively address recent advances in knowledge on the effects and treatment of trauma in general and sexual abuse specifically. For example, recent knowledge on the neurological effects and treatment of trauma includes the research of Perry (2006) and van der Kolk, (2002) that address the chronic, neurological effects of trauma on brain development. Perry illustrates how developmental issues on the neurological level caused by trauma can be addressed using patterned, repetitive sensory input. van der Kolk indicates that high levels of arousal interfere with the frontal areas of the brain often causing these areas to deactivate. The deactivation of these areas makes the processing of trauma difficult for the individual. The information on neurological effects was included in creation of the clinical model and unique DMT methods are included that directly address this issue on the body and mind levels. The structured format of this model presents DMT methods and theories in a new way that encourages dance/movement therapists and non-DMT therapists to use this model with sexually abused and otherwise traumatized individuals.

5.10 Limitations of the Study
The literature review documents that the study and treatment of sexually abused children and adults did not escalate until the 1980’s in DMT and other fields of therapy. Based on this temporal information, a focus on the literature from the past ten years was considered a reasonable and appropriate scope for this review. I attempted to include all relevant DMT literature both foundational and recent. In some cases, DMT literature was limited to use of relevant facts in the study rather than not including the source at all.

There was however, a large volume of non-DMT literature within this ten year scope than could not realistically be covered in this study. In some areas, it was possible to reach the point of saturation for information on sexually abused or otherwise traumatized children such as in psychoanalytic psychotherapy and music therapy. However, in a few areas such as CBT and play therapy, I made an informed decision on the literature to include or leave out of the study. In general, literature was excluded that focused on specific individual case studies, children exposed to single traumatic events or witnesses to events but not directly involved, unique groups of people with a specific traumatic experience such as a war, the treatment of one specific symptom, and multiple very similar works by the same researcher(s).

The review was generally limited to Western literature, which created a more limited view of effects and treatment of sexually abused and otherwise traumatized children. This limitation to western literature was due to some difficulties locating other cultural literature, the inability to translate materials, and that inclusion of literature from all cultures was beyond the scope of the study.
A final limitation of this study is that it is a theory based study informed by literature that has not been tested by a controlled research study with human participants. Therefore the results have not been tested to validate their effectiveness.

5.11 Implications for Future Research

This research study reveals that review of the literature on treating trauma and sexual abuse in children is beyond the scope of one individual study. In future research, it would be beneficial to divide the literature into smaller more focused areas of study to better represent all literature in each area. In terms of DMT specific research, it would be beneficial if data on adult survivors and children separate to better represent the relevant literature in a specific study. This research study demonstrates the need for an increase in research and publications on the use of DMT with traumatized or sexually abused children specifically. It is recommended that this DMT clinical model be tested using a group of sexually abused, school aged children. This research could provide data to either support or refute this model and provide important information on any changes needed to make the model more effective. In addition, a controlled research study could provide results generalizable to a population of sexually abused school aged children.
CHAPTER 6: SUMMARY AND CONCLUSIONS

In this research study a comprehensive DMT clinical model was created for therapy with school aged children who were victims of sexual abuse. The clinical model was created by reviewing literature that addressed the effects and treatment of these children specifically, and for other forms of childhood trauma. Overall, the literature review provided a rationale for inclusion of body based methods in treatment of trauma. The literature review was initially limited to the past ten years, however foundational sources on the same topics were also reviewed to provide a context that informed recent developments in the field. Relevant information from all sources, except DMT, was abstracted and organized into three review matrices based on Garrard’s Matrix Method (Garrard, 2004). The review matrices were analyzed to compare the literature and find themes in the effects and treatment of this population. The identified themes for effects and treatment were combined into eight overall treatment categories. All literature pertaining to DMT used with sexually abused children, otherwise traumatized children, and adult survivors of trauma or childhood sexual abuse was also reviewed. Relevant information from recent DMT work was abstracted into a fourth review matrix. Foundational DMT literature that was not included in Matrix 4 was used to inform creation of the model using DMT methods. The treatment categories were used to
identify the needs of sexually abused children and create a framework to address in the model using literature in Matrix 4 and general methods and theories of DMT.

The analysis of the literature revealed that abused and otherwise traumatized children are a very diverse group with complex issues, and no set syndrome is seen in most children. It is a challenge to create a treatment model that is set and specific with interventions that treat specific symptoms. Therapists need flexibility when working with this population and must be ready to adjust interventions for individuals or a group. Based on this information, the model was created with a long term format and no set number of sessions and interventions to allow therapists to alter the model to meet the needs of their clients. The group therapy format used in this model is based on strong support in the literature on the effectiveness of using groups with this population. It is recognized that long term therapy, and sometimes group therapy, is not always an option. Therefore, the model has a flexible structure that allows therapists to adjust treatments based on both the specific needs of their clients and the restrictions imposed on treatment. Therapists using this model need to understand that it provides guidelines, concepts, and suggestions but is not a complete intervention that can be used exactly with all abused or otherwise traumatized children.
List of References


## Appendix A: Matrix 1, Effects in children who were victims of trauma in general or sexual abuse (SA) specifically

<table>
<thead>
<tr>
<th>Author</th>
<th>Level of evidence, type of study</th>
<th>Population SA/trauma, both</th>
<th>Symptoms</th>
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</thead>
</table>
| 1. Atwood & Donheiser (1997)   | Clinical description            | SA                        | • Instead of learning about their autonomy and individuality, learn how to interpret and meet the demands of their abuser.  
• They are constantly trying to survive both physically and psychologically.  
• If abuse continues, the child eventually develops a “false self” due to learning to not making a distinction between their psychological self and that of the abuser. The “false self” is developed to satisfy the abuser’s needs and receive love from them. They learn to suppress their true self for fear that showing this self will upset the abuser and cause more abuse. |
| 2. Bannister (2002)           | Book describing theory          | Trauma                    | • Dissociation is often used as protective mechanism, that leads to children feeling separate or cut off from their bodies. Fragmentation of the child’s sense of self makes it difficult for them to form an integrated identity.  
• They develop somatic symptoms that often result from excessive use of dissociation. Often have a strong need to dissociate or disown their feelings, especially feelings that are too large and overpowering to handle.  
• Trauma has negative effect on attachment and development, can lead to problems with sense of identity. |
• SA children learn to cope and adapt to the abuse and their adaptive behavior becomes a part of their personality. Therefore their behavior is often not seen as a problem until later on in their development when problems begin to arise for the child.  
• Some children who have been victims of SA develop a disorganized pattern of attachment.  
• They see their caregivers as scary or sometimes the caregivers are seen as being scared as well.  
• If a child is abused by a caregiver, they have difficulty thinking that their caregiver could be bad so instead see themselves as bad and their abusers as good. This attachment style and underlying beliefs cause problems in relationships. Sexual abusers damage the child’s attachment by building and strengthening their attachment with the child and also by trying to destroy the child’s other attachment relationships with non-abusing adults. |
<table>
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<tr>
<th>4. Ben-Asher &amp; Koren (2002)</th>
<th>Single case study</th>
<th>SA</th>
<th>The child often sees themselves as helpless, angry, and unworthy.</th>
<th>Symptoms include: Introverted, hard to reach, lack of eye contact, don’t directly relate to others, need to control space between self and others, limited use of imaginary play, no spontaneous movement, restless/lack of calm movements, ambivalence between wanting to connect with others and feeling distrustful, lack of physical closeness, movements arise peripherally w/ very little connection to center of body, sharp/broken/stiff movements, lots of physical activity, desire to undress, point out/expose private parts, strong state of arousal, risky physical behaviors, trying to cause bodily harm, aggression, anger, anxiety, need to cleanse body, making hiding places.</th>
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<td>5. Briscoe-Smith &amp; Hinshaw (2006)</td>
<td>Comparative study, N=228</td>
<td>Abuse, ADHD</td>
<td>Results demonstrated that the girls with ADHD and a history of abuse were unique from other children with just ADHD in terms of their level of externalizing behavior and peer rejection.</td>
<td>The abused girls tended to be described as significantly more aggressive and experience more social rejection. Found that their peer rejection was mediated to some degree by their high rates of aggressive behavior.</td>
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<td>6. Chaffin, Wherry &amp; Dykman (1997)</td>
<td>Descriptive study, N= 84</td>
<td>SA</td>
<td>The most common coping strategies used were labeled: avoidant, internalized, angry, and active/social coping.</td>
<td>Each coping strategy was linked to a unique set of abuse characteristics and abuse-related environmental characteristics in addition to a unique set of abuse-related or behavioral symptoms.</td>
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</table>
Attachment: when trauma occurs as part of a parent-child relationship children often develop insecure attachment patterns, most damaging is disorganized attachment. Problems in attachment patterns cause life long risks of physical disease and psychosocial problems. 
Biology: children with traumatic histories are at risk for not developing brain functions to modulate emotions in response to stress. When faced with stress these children have a tendency to not be able to analytically assess a situation that makes them disorganized cognitively, emotionally, and behaviorally and are apt to react with severe helplessness, confusion, withdrawal, or rage. 
Affect regulation: problems both in being able to correctly identify internal emotional experiences and being able to express emotions in a safe way, and to modulate or regulate internal experiences. 
Dissociation: use dissociation to cope with their traumatic experiences, and when the traumatic exposure is chronic the child may begin to over rely on dissociation causing increased difficulties with managing behaviors, regulating affect, and with their self-concept. Often have difficulty being able to self-sooth. Dissociation helps these children to adapt by causing automatic behaviors, compartmentalization of painful memories/feelings, detachment from awareness of emotions/self. 
Behavior regulation: Uncontrolled and overcontrolled behavior patterns are seen in traumatized children. Both of these types of behavior patterns may be a result of the re-enactment of specific aspects of traumatic experiences. Using these behavior patterns allows child to develop a sense of mastery and control over the re-enactments and their behaviors, and allows them to avoid intolerable levels of emotional arousal. Complex trauma exposure can lead to the loss of important skills for self-regulation. |
• **Cognition:** Show cognitive impairments as early as late infancy. By early childhood these children show less flexibility and creativity in problem-solving tasks and by early elementary school age they are often referred for special education services.

• **Self concept:** Often have a negative self-concept and tend to react to recognition with neutral or negative affect. Their negative experiences lead them to develop as sense of self as defective, helpless, deficient, and unlovable, making them more likely to blame themselves for negative experiences and have trouble getting and accepting outside support. Complex trauma exposure leads to the loss of important skills for interpersonal relations.

Quantitative comparative study, N= 44 mothers & N= 44 children  
SA  
- Effects of SA include: Posttraumatic stress, age-inappropriate sexual behaviors, depression, fears related to abuse, anger, guilt and shame, sleep disturbances, hostility, and behavior problems.
- Although children may not show many negative effects soon after the abuse has stopped, they may develop these issues as they develop and gain a better understanding of what they experienced.

Multiple baseline design to test controlling effects of previous TF-CBT, N=4  
Abuse, PTSD  
- Effects of trauma on children include medical and other health problems.
- It is now generally accepted that PTSD can occur in any traumatized child.

Case example, clinical description, theory  
SA  
- Effects of SA include: Post traumatic stress and PTSD, emotional problems such as altered emotionality due to the disregulation effect of the trauma, dissociative symptoms, eating disorders, fear, anxiety, aggression particularly sexual aggression, poor self-esteem, academic difficulties, issues concerning the development of self and healthy attachments, sleep disturbances, behavior problems such as behavioral dysregulation, cognitive distortions, damage to relationships with adults and peers.
- Each abused child has their own unique set of symptoms that need to be addressed on a case by case basis. They develop unique defense techniques to cope and survive and try to make their own meaning about what they experienced.
- Interpersonal problems and a lack of social skills.

Observational study, DMT  
SA  
- Observed movement characteristics of sexually abused boys: 1) quickness, 2) awake state, 3) hollowing and narrowing shape flow, 4) vertical spatial stress, 5) holding of the torso tightly, 6) using only distal body parts, 7) shallow breathing, 8) lack connectivity to inner self, 9) no self touch as if not aware of own body.

Book describing theory  
Trauma  
- Development of insecure attachment patterns that can effect a child’s development and create identity problems.
- Effects on development include (in terms of Erikson’s stages of development): 1) an overwhelming sense of mistrust of the world and others, 2) don’t achieve a sense of autonomy, 3) doubt their independence and abilities, 4) don’t have a strong sense of self and of their body, 5) learn to doubt own sense of judgment.
6) feel guilty for thoughts, fantasies, and actions, 7) show difficulty using newly mastered skills making them feel inferior to peers, 8) may identify with aggressor or be forced to take on more adult role that causes confusion and memory problems.

- Constantly anxious due to fearful reminders of their traumatic experiences and frequently show separation anxiety and stranger anxiety more than is healthy.

- Other effects include: 1) increase in anger and aggression, 2) depression, 3) school related issues such as issues of overall performance and discipline, 4) irritability, 5) hypervigilance, 6) sleep disturbances such as nightmares, intrusive thoughts, images, and sounds, 7) restricted affective experiencing or emotional numbing, 8) reenacting of the traumatic incident, 9) insecurity, 10) fear in general as well as fear of further trauma, 11) guilt, 12) reduced impulse control, 13) intrusive thoughts/reliving of traumatic memories, 14) separation anxiety or overanxious disorder, 15) problems with trust, and 16) risk of future sexual promiscuity, unsafe sex practices, and alcohol and drug use.

- Show age inappropriate behavior such as whining, clinging, and temper tantrums.

   - Quantitative study, N=156 time one, N=73 time two
   - SA

- Children who report having dissociative symptoms after disclosing sexual abuse and/or were sexually abused by a member of their family were found to be at an increased risk of developing attention problems.

   - Literature/research review
   - Childhood abuse, PTSD (no specific age group described)

- Discovered that people with PTSD have abnormally low levels of cortisol and abnormally high levels of norepinephrine.
- People with PTSD appear to have a dysregulated stress response. Instead of having cortisol and norepinephrine operate together as a stress response, when someone has PTSD, they operate separately.
- Trauma survivors with PTSD can be hypersensitive to environmental and external events, and may become hyper-aroused and respond accordingly even when the event or stimuli is neutral.
- Found a body level effect of abuse through the connection found between irritable bowel syndrome (IBS) and childhood abuse. The symptoms include: abdominal pain or cramping, diarrhea or constipation, and bloating or abdominal distention.
- According to the research IBS comes from being hyper-aroused and focused on pain. Pain has a strong mind-body component that provides support for the connection between IBS and childhood abuse.

   - Quantitative study
   - N=60 one sample
   - N= 40 one sample
   - SA

- Type 1-- Developmentally “expected” sexual behavior that includes children who do not show any developmentally problematic sexual behavior, and experienced pain and discomfort during abuse but are not sexually aroused.
- Type 2-- Unplanned, interpersonal sexual behavior (developmentally problematic) that includes children who exhibit problematic interpersonal sexual behavior that is spontaneous, episodic, and not entrenched that is different than the other types, and they experience pain and discomfort during abuse but no sexual arousal.
- Type 3-- Self-focused sexual behavior (developmentally problematic) that consists of children who display frequent and compulsive masturbation and sexual preoccupation but not many sexualized gestures and no problematic interpersonal sexual behavior, and experience little pain and discomfort but abuse leads to more sexual arousal.
<table>
<thead>
<tr>
<th>Study Reference</th>
<th>Methodology</th>
<th>Trauma Type</th>
<th>Highlights</th>
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</table>
| Lumsden (2006)   | Theory, DMT | Trauma      | - Type 4: Planned, interpersonal sexual behavior (developmentally problematic) that includes children who engage in problematic interpersonal sexual behavior including extensive adult-type sexual acts, are sexually preoccupied and display problematic levels of masturbation, and the abuse is uncomfortable, sadistic and arousing.  
- Type 5: Planned, coercive interpersonal sexual behavior (developmentally problematic) consisting of children who exhibit extensive, adult-type interpersonal sexual behavior, high levels of problematic masturbation as well as sexual preoccupation and sexualized gestures, and their abuse involves discomfort, self-stimulation and arousal. |
| Moore, Armsden & Gogerty (1998) | 12 year follow up investigation of a randomized controlled trial, N=35 for follow up or N=61 | Maltreatment | - Current research in traumatology has revealed two types of trauma, simple and complex. Complex trauma leads to complex somatic, emotional, cognitive, and social symptoms. The complex nature of these issues requires complex therapies. |
| Ogden, Pain & Fisher (2006) | Theory, clinical description | Trauma (no age group specifically discussed) | - Describes additional symptoms that are mainly bodily responses to dysregulated affect.  
- These symptoms cause these individuals to also meet the diagnostic criteria for disorders including: mood disorders, anxiety disorders, substance abuse and dependence disorders, eating disorders, somatoform disorders, and medically unexplainable symptoms. |
| Perry (2006) | Theory | Trauma | - Important to understand brain development and functioning to understand abnormal functioning that occurs after experiencing abuse and trauma.  
- Key information concerning the neurological effects of trauma in children:  
  1) If a pattern is novel or matched with a previous pattern associated with threat the body will trigger an alarm response. This causes an internal state of arousal that moves up through each part of the brain causing neural activity.  
  2) The symptoms a traumatized child displays are directly related to their history of neural activation or lack of activation. If a child is neglected, the deficits they have will be in the areas where the neglect specifically occurred.  
  3) Stress responses originate in the lower parts of the brain and if there is damage to these parts it dysregulates and disorganizes higher parts of the brain.  
  4) Children are more vulnerable to trauma than adolescents or adults, and the younger the child is the more enduring and pervasive the issues are that develop.  
  5) Once an area of the brain is organized it is less able to change but some parts of the brain such as the
cortex stay significantly plastic throughout life.

6) The brain prefers the environments of the past to current over-stimulated, distracting, and relationally lacking environment.

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<td>• Traumatized people, especially from abuse, often can’t be touched without getting overwhelmed or “going dead” in their bodies. Touch by even a safe and caring therapist can trigger memories of traumatic events, sometimes because the therapist is transferentially perceived as the perpetrator.</td>
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<td>• The experience of hyper-arousal creates sensitivity to everything.</td>
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<tr>
<th>22. Rothschild (2002)</th>
<th>Theory, clinical descriptions</th>
<th>Trauma (no age group specifically discussed)</th>
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<tr>
<td>• The traumatized individual often loses control over bodily functions that can be very humiliating.</td>
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<tr>
<td>• Traumatic events are stored as implicit memories that are unconscious and made up of emotions, sensations, movements, and automatic procedures. These memories are often called body memories or somatic memories because they are stored and remembered through an inter-communication between the brain and the body’s nervous system, and are often expressed in biological stress responses.</td>
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<tr>
<th>23. Scott, Burlingame, Starling, Porter &amp; Lily (2003)</th>
<th>Case study N=26, N=24 at 2 month follow up, assessment done before and after therapy</th>
<th>SA</th>
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<tr>
<td>• Symptoms resulting from SA include: drug and alcohol abuse, fears related to the abuse, anger, aggression, guilt and shame, poor self-esteem, a poor self-concept, hostility, anti-social behavior, stealing, tantrums, delinquency, cognitive distortions, mood disturbances, sexual identity problems, and somatic issues.</td>
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<td>• The issues of social isolation in SA children are believed to be caused by inappropriately acting out sexually and withdrawing into fantasy or withdrawing to avoid possible re-traumitization or reminders of the abuse.</td>
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<td>• It is now generally accepted that PTSD can occur in any traumatized child.</td>
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<td>• Childhood trauma, especially chronic trauma, has many negative effects on child development. The trauma interferes with a child’s ability to integrate sensory, emotional, and cognitive information into a cohesive whole and leads to unfocused and irrelevant responses to future stress.</td>
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<tr>
<td>• Suffer developmental delays in the areas of cognition, language, motor, and socialization skills.</td>
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<td>• Unable to process and understand physical sensations to appropriately respond. This inability effects body functioning.</td>
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<tr>
<td>• They often have impaired pain perception and problems with coordination, balance, and body tone. They also may easily get disoriented in space and time. Some traumatized children respond to stress by freezing, avoidance and sensorimotor constriction.</td>
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<td>• Early childhood—inappropriate sexual behavior, internalizing, externalizing. Middle childhood—depression, suicidal ideation, PTSD, sexual anxiety, inappropriate sexual behavior, internalizing, externalizing, and Adolescence—risksy sexual behavior, depression, suicidal thoughts, suicide, internalizing (low self-esteem), PTSD, externalizing (anti-social behavior), substance use, gang involvement, pregnancy, running away.</td>
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</tbody>
</table>
| 27. Truppi (2001) | N=21Quantative study, DMT | SA | • SA children often feel that they could have done more to prevent the abuse or have disclosed the abuse earlier that makes them feel bad about themselves.  
• They may develop: sexual identity problems, sexual problems, sexual compulsivity, somatic issues, somatization, self-mutilation/suicidality, obsessions/compulsions, and dissociative identity disorder.  
• SA children tend to: 1) feel as though they are different from their peers, 2) blame themselves for negative events, 3) lack interpersonal trust, and 4) have lowered credibility.  
• The violation of the body in sexual abuse significantly effects both the body and psyche. Sexual abuse has significant negative effects on the victim’s body image.  
• The victim often feels persistently dirty and shameful. The damage that is caused by abuse is exhibited in the body through rigidity and somatization.  
• Eating disorders and self-mutilation are often seen in victims of sexual abuse and appear to serve as maladaptive coping responses. The purpose of these behaviors seems to vary from person to person. |
| 28. van der Kolk (1999) | Theory, descriptions of previous research | Trauma (no age group specifically discussed) | • A constant high level of arousal causes the primitive areas of the brain, the limbic system and the brain stem, to generate sensations and emotions that contradict conscious beliefs and knowledge.  
• A hyper-aroused person may respond with irrational behavior to stimuli that are in fact neutral or just stressful and not traumatic.  
• The amygdala is central to creating traumatic re-experiencing because it interprets the threat of incoming sensory information. The amygdala creates emotional memories from specific sensations, sounds, and images related to threatening situations. These memories become set so that when specific sensations are re-experienced a traumatized person is likely to respond with flight or fight reactions as if in danger regardless of the actual situation.  
• People with PTSD show a failure to habituate to CNS and autonomic nervous system (ANS) mediated responses to ASR.  
• Traumatized individuals often attempt to compensate for hyper-arousal through emotional numbing and “shutting down” to avoid stimuli that may be reminiscent of the trauma. They eventually end up shutting down in everyday experiences as well as trauma related experiences.  
• Dissociation is often a coping mechanism used to numb the pain and separate the body and mind. Individuals with PTSD experience a heightened physiological arousal to sounds, images, and thoughts that are connected to traumatic experiences.  
• Research has determined that these individuals have conditioned autonomic responses to trauma related stimuli such as increased heart rate, skin conductance, and increased blood pressure. The intense responses can occur years and even decades after the trauma occurred; traumatic memories can powerfully and continuously effect a person’s life. |
<table>
<thead>
<tr>
<th>29. van der Kolk (2003), Streeck-Fischer &amp; van der Kolk (2000)</th>
<th>Literature review &amp; clinical observation (overlapping information)</th>
<th>Trauma</th>
</tr>
</thead>
</table>
|                                                               |                                                                | • Effects include: 1) dissociation, 2) depression, 3) PTSD, 4) suicidality and risk of future suicide attempts, 5) separation anxiety/overanxious disorder, 6) phobic disorder, 7) attention deficit hyperactive disorder (ADHD), 8) oppositional defiant disorder (ODD), and 9) conduct disorder.  
• Often have difficulty controlling their emotional responses and modulating their behavior. They still try to stabilize their emotional lives through emotional constriction and avoidance often seen in their dissociative symptoms. They usually become aware of their lack of control that makes them to hate themselves and since they can’t control these things they often self medicate through drugs, starving and binging, or self-injurious behavior.  
• Some develop dissociation of the personality where they deal with stress by splitting their personality into different entities. This makes the child unable to integrate different states of emotional engagement and makes them feel as different people at different times.  
• They may develop various learning difficulties many that are related to attentional disorders. These disorders are caused by their inability to distinguish between relevant and irrelevant information, and fear of unexpected and novel stimuli and information. These children are “easily overstimulated and cannot achieve the state of secure readiness that is necessary to be open to new information” (p.912).  
• They experience the world as a scary place and therefore taking risks and being curious is very difficult for them.  
• Often have auditory and visual perceptual problems.  
• When stressed often return to earlier developmental levels or take on different ego states from infantile to near psychotic to hyper-mature.  
• Often so preoccupied with keeping themselves safe that they never have chances to be playful and use their imagination to interact with the outside world.  
• They have difficulty playing and if they do play it is often rigid and constricted with the same topics constantly repeated with no changes over time. These children experience distress and helplessness when playing while healthy children experience mastery and pleasure. They experience ambiguous or affectively charged stimuli that come up in play as if they were back in a traumatic situation.  
• Show neurobiological dysregulation that has long term effects that include: 1) the loss of self-regulation that includes emotional regulation and problems with self-definition, 2) learning and memory issues caused by becoming hypervigilant that effects how one organizes their perceptions of the world, 3) social problems due to difficulties reading social cues and adapting arousal levels, 4) physical issues including cancer, heart disease, and diabetes, 5) drug abuse, 6) self-mutilation, and 7) violent and aggressive behavior towards others. |
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<thead>
<tr>
<th>30. van der Kolk (2002)</th>
<th>Theory</th>
<th>Trauma</th>
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<tbody>
<tr>
<td>• Individuals with PTSD experience psychophysiological reactions and neuroendocrine responses when in contact with stimuli from the original trauma. This indicates that traumatized individuals have developed a conditioned response to certain reminders of the trauma. The conditioned response initiates a flight or fight biological system response as if the person were experiencing the traumatic event again.</td>
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<td>• People with PTSD develop abnormalities in the neurotransmitters that regulate arousal and attention. Naturally stress activates two stress hormones catecholamines and cortisol, but in PTSD there are low levels of cortisol.</td>
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<tr>
<td>• When low levels of cortisol are combined with increased levels of norepinephrien, the individual becomes more reactive to arousing stimuli that is the case with PTSD. These individuals experience indiscriminate flight or fight reactions.</td>
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<tr>
<td>• Research that has examined the reaction of the brain to various challenges has revealed that “when people are frightened or aroused, the frontal areas of the brain, that are responsible for the analysis of experience and associating it with other areas of knowledge, are deactivated” (p.385).</td>
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<td>• In people who have PTSD the deactivation of the dorsolateral prefrontal cortex that is the place of executive functioning interferes with the ability to come up with a specific measured response to a threat.</td>
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<tr>
<td>• High levels of arousal interfere with the functioning of Broca’s area that is used to put feelings into words. This means it is difficult for victims of trauma to verbally express how they feel.</td>
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### Appendix B: Matrix 2, Treatment concerns and overall guidelines for work with sexually abused or otherwise traumatized children

<table>
<thead>
<tr>
<th>Author</th>
<th>Level of evidence/type of study</th>
<th>Pop: sexual abuse (SA)/trauma/both</th>
<th>Guidelines</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amand, Bard &amp; Silvosky (2008)</td>
<td>Meta-analysis of 11 studies</td>
<td>Maltreatment</td>
<td>• The benefits of group format treatment include:  1) a reduced sense of social isolation and sense of being “different”  2) a chance to learn different patterns of interaction with other children and adults  3) cost-effectiveness  4) positive peer pressure and modeling from peers in the group  5) experiencing positive interactions and getting feedback from peers  6) gives the therapist a better opportunity to more easily assess the client’s social perceptions and skills</td>
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<tr>
<td>2. Cohen, Berliner &amp; Mannarino (2000)</td>
<td>Review of research and treatment methods</td>
<td>Trauma</td>
<td>• Found that the effects of SA on children are diverse; there is no specific syndrome.</td>
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<td>3. Cohen, Deblinger, Mannarino, de Arellano (2001)</td>
<td>Empirical review</td>
<td>Abuse &amp; neglect</td>
<td>• Treatment of abuse and neglect touches on issues that are very influenced by ethnic and religious beliefs.  • These issues include:  1) different views on sexuality, nudity, discipline practices, parent/child relationships,  2) cultural norms and expectations concerning children’s behavior within the family and the community at large,  3) varying ways that adults and children interact,  4) different emotional and behavioral parental reactions to sexual abuse disclosure that significantly affects child’s recovery.  • Therapists need to understand when developing</td>
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<td>Source</td>
<td>Source Type</td>
<td>Topic</td>
<td>Key Points</td>
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<td>Therapeutic relationships how culture affects a child and family in therapy.</td>
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<td>• Cultural background affects how much clients are willing to discuss, how they feel about therapy, their emotional and behavioral symptoms, attitudes towards child abuse, and child-rearing practices.</td>
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<td></td>
<td>• Depending on the child and family, multimodal treatment and several levels of care may be needed.</td>
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<tr>
<td>Cook et al. (2005)</td>
<td>Literature</td>
<td>Trauma</td>
<td>• Important aspect of therapy is to form a trusting relationship with a traumatized child that requires empathetic attunement but this is often difficult.</td>
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<tr>
<td></td>
<td>review</td>
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<td>• Developing a trusting relationship is important because it is through this relationship that the child starts to risk being close to others and it is through empathetic responses that he child learns to feel empathy towards self and others.</td>
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<td>• Give them the chance to tell their story verbally or symbolically through play and have it understood and witnessed by someone they trust.</td>
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<td></td>
<td>• When a child has this experience they are able to begin making a new story for themselves and creating new meaning and perspective on life.</td>
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<td>• If these children are able to continue to be accepted after sharing secret and shameful things about their traumatic experiences, they can learn to accept themselves.</td>
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<td>• It’s essential that therapy is guided by the child’s needs and not by the therapist’s own interpretations of what they child needs or what constitutes good therapy.</td>
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<td>• Be careful not to back off or discourage a child from expressing in some way their traumatic experiences once they have reached the point of being ready because this would be detrimental to the child and would leave them to work through these things alone.</td>
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<tr>
<td>Edwards &amp; McFarren (2004)</td>
<td>Theory, teaching suggestions</td>
<td>SA</td>
<td>• Since there is great diversity in the psychopathology of these children most likely one form of treatment will not meet the needs of all clients.</td>
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<td>• Sometimes despite treatment some children do not improve or become worse.</td>
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<td>• Not clear what the optimal duration of treatment is and the drop-out rate is a significant problem.</td>
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<td>• It is still unclear whether asymptomatic children should be treated.</td>
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<td>• Some clinicians believe boys are harder to treat than girls.</td>
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</table>
| 7. Feiring & Cleland (2007) | Longitudinal, interview study, org N=160, @ 1yr N=147, @ 6 yrs N= 121 of original participants | SA | • A larger problem beyond treatment specifically is that intrafamilial sexual abuse often happens in an environment with personal, familial, and community problems that need to be addressed as well.  
• Important to keep in mind when planning interventions that attributions are complicated and that blame is not a unipolar dimension.  
• One can not assume that by encouraging a child to blame the perpetrator the possibility that the child will blame themselves will be reduced.  
• Helping abused children to become aware of and reflect on abuse-specific attributions is one method to help them start to reevaluate the assumptions that they have made concerning their victimization and create healthier views of themselves and others. |

| 8. Henry (1997) | Comparative study, N=90 | SA | • Although abused children have been betrayed by adults most of them are still willing to develop relationships with caring adults.  
• These caring relationships can perhaps help counteract previous betrayal and give these children a chance to feel safe and secure that is an important part of psychological and emotional recovery and can reduce the possibility of further trauma.  
• Interventions by professionals need to respect the integrity of the children in their own eyes.  
• Don’t make the mistake of making promises to abused children that are not guaranteed because this can damage the child’s level of trust in the professional.  
• When children are forced to repeatedly repeat their abuse experiences it can connect them with painful memories that has the potential to reinforce the internalization of guilt and shame created by the sexual abuse.  
• Being able to develop trusting relationships with professionals can be harmed when children are asked the same questions repeatedly.  
• When working with children to disclose information about their abuse it is crucial that the person providing the intervention be open and honest with the child about what might happen once they disclose and answer the child’s questions in terms of placement, perpetrator incarceration, and possible familial responses.  
• If these precautions are not taken the child may easily feel betrayed when these situations occur. |
<table>
<thead>
<tr>
<th></th>
<th>Study (Year)</th>
<th>Type</th>
<th>Abuse Type</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Johnston (1997)</td>
<td>Literature review</td>
<td>Abuse including SA</td>
<td>Therapists using anatomical dolls need to be aware that observing sexualized play with dolls isn’t enough on its own to clearly indicate SA. Conversely, even if sexualized play isn’t seen that doesn’t rule out the possibility of SA for the child.</td>
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<td>10.</td>
<td>Saywitz, Mannarino, Berliner &amp; Cohen (2000)</td>
<td>Literature review</td>
<td>SA</td>
<td>Essential to include caretakers in the therapy process of SA children whenever possible. This allows the caregivers to manage the child’s symptoms outside of therapy using therapeutic techniques, monitor the child’s symptoms over time, help to prevent re-victimization, and work to make improvements in the family environment. The caregiver’s involvement in the treatment process also assists work on their own feelings of distress and other issues surrounding their child’s abuse. This will ultimately help the child.</td>
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<td>11.</td>
<td>Wanlass, Moreno &amp; Thomson (2006)</td>
<td>Case study of single group N= 8-12</td>
<td>Abuse</td>
<td>Containment can be provided through establishing boundaries and providing specific structured activities. The upsetting and overwhelming nature of the issues held by abused children require that the group therapy leaders provide containment and support for the members as they work through these issues.</td>
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</table>
### Appendix C: Matrix 3, Specific treatment models and methods used with sexually abused or otherwise traumatized children

**Note:** Most treatment methods/models used for children but some used with all ages or with adults modified for use with children

<table>
<thead>
<tr>
<th>Author</th>
<th>Level of evidence/type of study</th>
<th>Pop: SA/trauma, both</th>
<th>Treatment methods/models</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ahmad &amp; Sundelin-Wahlsten (2008)</td>
<td>Randomized control trial study, N= 33</td>
<td>PTSD</td>
<td>• <strong>Child-adjusted EMDR</strong> protocol was applicable after modifications were made to take age and developmental level of the child into consideration.</td>
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<td></td>
<td>• Adjustments were made based on the child’s age and developmental level because the ability to identify positive and negative cognitions and emotions is based on these things.</td>
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<td>• EMDR used with children allows the therapist to explore their thoughts and feelings and help them learn to identify their thoughts and feelings in specific situations and recognize positive versus negative cognitions.</td>
</tr>
<tr>
<td>2. Aposhyan (2004)</td>
<td>Theory</td>
<td>Trauma (no age group specifically discussed)</td>
<td>• In <strong>body-mind psychotherapy</strong>, the therapist focuses on restoring the client’s concept of safety in their body rather than in the environment outside their body, that is less controllable.</td>
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<td></td>
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<td>• This treatment is initiated by helping the client identify areas of safety in their body that can subsequently provide actual support for the less safe areas. If the client can recognize centers of fear in their body they can learn to listen to these fears, express them, and come to the realization that the threat is gone.</td>
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<td>• The act of creating physical support and protection helps make the body become more convinced that it is possible for the future to feel safe, unlike the past.</td>
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<td>• Body-mind psychotherapists believe that by defining the physical responses, clients can learn to recognize their own traumatic responses and work towards developing embodiment. This is important because people involved in a traumatic experience often dissociate and do not pay attention to their body state.</td>
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<td>• Body-mind psychotherapists instruct clients to check in on the effects of shock on all their body systems to teach them how to evaluate the presence and degree of shock. The ability to recognize different levels of shock in their body allows clients to be more present and embodied rather than detached or in shock.</td>
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<td>• See chapter for specific details on techniques that are used to help develop embodiment, and engage different nervous systems.</td>
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<tr>
<td>3. Bannister (2003)</td>
<td>Description of treatment model</td>
<td>Trauma</td>
<td>• Theories of the <strong>Regenerative model</strong>: 1) being child centered, the child is allowed to lead but still interact with the therapist, 2) maintaining awareness of the development processes occurring in the child, 3) being aware that play is a method of growth, 4) emphasizing safety by using symbolism, metaphors, and containment/boundaries, and 5) tending towards action and the use of the body.</td>
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<tr>
<td>Source</td>
<td>Type</td>
<td>Method</td>
<td>Description</td>
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<tr>
<td>Buckland &amp; Murphy (2001)</td>
<td>Clinical description</td>
<td>SA</td>
<td>Activities in group art therapy included: 1) large group paintings by all children and the therapist that symbolize the shared journey, 2) paintings that show how the children feel towards their abusers, and 3) sitting at a table together with snacks and drinks for a discussion and processing of the group.</td>
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<tr>
<td>Carbonell &amp; Parteleno-Barehmi, (1999)</td>
<td>Comparative pre and post study with treatment and control group, N=28</td>
<td>Trauma</td>
<td>Each session of the psychodrama treatment consisted of three phases: 1) warm-up, 2) action, and 3) sharing. All phases had a balance of structure and spontaneity to ensure experiences of safety and competence. In beginning of treatment the warm-up phase is also used to introduce all group members and the group leaders, present the general format and parameters of the sessions, and create group rules and norms that help members learn to trust and respect each other, keep information confidential, and give all members the chance to express themselves. The action phase allows the children the opportunity to reenact the traumatic event by showing as well as telling about what occurred. Reenactment is important in psychodrama and helps clients get in touch directly with their senses and create an emotional connection to the traumatic experience. Children involved in reenactment have complete control over how they work through the trauma that is much different than the actual traumatic experience. It is up to the individual child who will play each part of the drama, how the roles will be expressed, the setting, and the outcome. In the sharing phase, all participants talk about what the experience of psychodrama brought up for them, concentrating on their feelings. Termination activities to end the therapy process focus on containment, connecting to others, choice, and self-efficacy that are all essential in the healing process of trauma.</td>
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<tr>
<td>Chemtob, Nakashima &amp; Carlson (2002)</td>
<td>Controlled study to measure effectiveness of treatment method, PTSD</td>
<td></td>
<td>The intervention consisted of one diagnostic session and three weekly treatment sessions. The treatment was comprised of four stages: 1) introduction and assessment, 2) worst memory, 3) current reminders, and 4) future events. The therapists used the diagnostic session to build rapport, explain the treatment, measure the presence or...</td>
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N= 32 absence of PTSD, and create a “safe place” with the help of the child using EMDR-like techniques.  
- In first treatment session therapist conducted two sets of eye movement procedures to install the safe place in the child’s mind. Next the most distressing memory about the disaster was used with the typical EMDR procedures. The first session ended with having the child concentrate on a positive cognition.  
- In the second treatment session the worst reminders of the disaster were processed.  
- The final session focused on the child’s fears about future disasters.  
- If other upsetting memories ever came up the therapist would address these using the EMDR techniques as well.  
- To end the treatment process, feelings concerning termination were discussed and gains from therapy were reviewed.  

| Clinical description, explanation of theory | Trauma (no age group specifically discussed) | - **Psychodynamic psychotherapy** can help to clarify the meaning and influence that traumatic experiences has on a client to understand their symptoms.  
- It’s important when working with trauma clients to: 1) recognize the extent that certain events have led them to lose some or all of their ability to cope with internal and external stimuli, 2) determine their typical coping skills, and 3) understand developmental and hereditary elements that may contribute to their ego strengths and vulnerabilities.  

| Clinical description, description of specific group treatment method | SA | - In **psychodrama** the group acts out a situation or experience of another member who is the main character of the story.  
- Use puppets, dolls, and stuffed animals instead of role playing because they allow the clients to be more in control as they work through painful experiences. Using these objects is also easier than role playing for very young children. The puppets can serve as a mirror or object for children to project their feelings onto that allows for feeling a sense of more distance and safety in the therapy process.  
- Other activities include: 1) giving the children cards with faces that represent different feelings and have them choose a card that reflects how they feel that day, 2) using fairy tales, as well as rhymes to address certain themes and issues, 3) strengthen a child’s feeling of their body and boundaries can be done by using a rhyme that is said as specific movements are done and the children can take turns leading the activity.  
- Fairy tales can be selected that involve an abused character and address the issues involved in this type of experience. Each child in the group has the chance to act out their abusive experience as well as to change the outcome as they wish.  
- Sometimes the leader will introduce a drama topic and encourage all members to contribute ideas. The leader may bring up themes that are common issues for this population as a teaching opportunity, particularly for sexual education. Common children’s games are used to give the children a chance to move around.  

| Quantitative study, N=49 | SA | - Specific interventions used during **Sexual Abuse Specific-CBT (SAS-CBT)** sessions include CBT methods: 1) building relationship-social skills 2) monitoring and modifying automatic thoughts, assumptions, and beliefs (cognitive reframing), 3) thought-stopping and positive imagery, 4) teaching problem-solving skills, 5) contingency reinforcement, and 6) modeling that includes role-playing, social reinforcement, and positive feedback.  

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| **12. Cohen, Deblinger, Mannarino & Steer (2004)** | **Multi-site, randomized controlled trial, N=229** | **SA/PTSD** | **This form of therapy includes parents because they see that the parent’s emotional reaction to the sexual abuse has a strong effect on the child’s symptoms.**  
**The goals for SAS-CBT with parents include: 1) decrease parental emotional distress, 2) enhance parental support of their child, and 3) manage behavioral difficulties of their child related to abuse.** |
| **13. Cohen, Mannarino & Deblinger (2006)** | **Theory, description of therapeutic model (book)** | **Trauma** | **In TF-CBT therapist help clients: 1) work on skills in expressing feelings, 2) training in coping skills, 3) recognizing the relationships between thoughts, feelings, and behaviors, 4) gradual exposure (creating the child’s trauma narrative), 5) cognitive processing of the abuse experience(s), 6) joint child–parent sessions that include psycho-education about child SA and body safety and teaching parent management skills.**  
**The three joint parent–child sessions were used to optimize comfortable communication, to provide education about personal safety and healthy sexuality, and to allow the child and parent to share and discuss the child’s trauma narrative together.**  
**As sessions progress in TF-CBT, children are encouraged to deal specifically with more detailed and distressing reminders and memories of the trauma or abuse.**  
**Children are asked to create narratives of their traumatic experience either by writing or drawing in a journal that, with their consent, is shared with their parents in joint sessions.** |
| **14. Crenshaw & Hardy (2007)** | **Clinical description, case example** | **Trauma** | **The components of Trauma Focused-CBT form the acronym PRACTICE: Psycho-education and parenting skills, Relaxation, Affective modulation, Cognitive coping and processing, Trauma narrative, In vivo mastery of trauma reminders, Conjoint child-parent sessions, and Enhancing future safety and development.**  
**Usually the components of TF-CBT usually addressed in the above order but therapist may blend components together or go back and revisit components that have already been presented but need to be reviewed.**  
**Since TF-CBT teaches specific strengths and skills to clients, it is important that children and their families practice the components of TF-CBT outside of therapy.** |
| **15. Deblinger, Stauffer & Steer (2001)** | **Controlled clinical outcome trial, N=44 mothers & N=44 children** | **SA** | **CBT vs. supportive therapy: Activities were selected that encouraged the children to: 1) communicate about and cope with their emotions, 2) identify “okay” and “not okay” forms of touching, and 3) learn abuse response skills.**  
**Because of the young age of the children in therapy (2-8yrs), they were never asked to talk directly about their abusive experiences although some children did disclose information. Instead, therapists used an interactive format with worksheets, role playing, behavior rehearsal, and activities that included both parent**
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| 16. Dripchak (2007) | Description of therapy method, case examples | Trauma | ● Therapists using this method of **play therapy** use both non-directive and directive techniques and focus on the present perceptions of the child and working towards future acceptance and resolutions.  
● Therapists make use of the child’s own abilities and natural resources internally and in their external environment.  
● This model allows children to use exploratory play to feel safe in the therapy environment and set their own pace in the initial stage of therapy.  
● Eventually once the therapist has determined what the traumatic themes are, they use directive techniques through metaphors, fairy tales, and storytelling to introduce new ideas to the child.  
● The therapist uses indirect suggestions, refractions where the therapist talks to the play toy, reflective statements, interspersed suggestions, and direct suggestions. This form of play therapy when done correctly is effective because it will not re-traumatize the child. |
| 17. Eaton, Doherty & Widrick (2007) | Literature review | Trauma | ● **Art therapy** techniques and structure used when working with this population includes developing a therapist-client relationship through creating art often using storytelling as well.  
● In the beginning of the therapy process the child creates art work with the therapist aiding them by providing appropriate materials and encouragement. Art making with children usually consists of pencil drawing, coloring, and using clay.  
● As therapy continues, therapists may ask the child to tell a story about the art they created while the therapist helps with the interpretation of the story. The storytelling allows for fantasy and reality to be separated that leads to self-discovery and cathartic release.  
● The child is given the opportunity to learn how to cope with the reality of the trauma and the related feelings. |
| 18. Farrell, Hains & Davies (1998) | Quantitative study, N = 4 | SA | ● In this study, the **CBT** included: 1) educational aspects, 2) self-monitoring, 3) relaxation training, 4) cognitive restructuring, 5) role-playing, and 6) in vivo practice of skills. |
| 19. Faust & Katchen (2004) | Descriptions of therapy methods, characteristics of complex trauma | Trauma | ● In general, **CBT** for this population has four procedures: 1) coping-skills instruction, 2) relaxation training, 3) systematic desensitization both imaginary and quasi in vivo, and 4) behavioral parent education that can have a focus on making a contract to increase compliance and reduce the fear response.  
● Specific to this study are 4 procedures in order: 1) the children are taught coping skills to help reduce anxiety as well as break the connection that has been made between anxiety and the reinforcing aspects of avoidance.  
● Coping skills also work to improve sense of mastery and self-worth, in addition to feeling more in control because the child is able to use the skills on their own to master their fear and anxiety.  
● Therapists teach them adaptive self-statements to support them during the desensitization process and to use when ever they come into contact with fearful stimuli outside of therapy.  
● Therapists help their clients identify and challenge maladaptive self-statements particularly those related to the trauma and resulting fear. The clients are also asked to create adaptive cognitions and attributions in addition to replacing maladaptive self-statements with adaptive ones. |
2) Children with PTSD are taught relaxation skills, utilizing techniques such as diaphragmatic breathing and progressive body-muscle relaxation that were developed especially for children. A modification made by therapists to the progressive body-muscle relaxation technique is to use imagery during the tense-relax phase of each muscle group. After this technique is done the therapist asks the child to imagine a safe relaxing place to go in their mind.

3) Children are asked to make a fear hierarchy with help from the therapist. A fear hierarchy includes stimuli that the child can verbally express as well as stimuli that are avoided. Often child is unable to come up with details of the traumatic event or fearful stimuli due to the avoidance aspect of PTSD. The caregivers can help fill in the gaps and provide other information not available to the child such as legal documents. The caregivers on their own make a fear hierarchy for the child as well.

4) Caregivers are taught about parenting skills that can improve their child’s coping such as rewarding the appropriate use of coping skills, teaching adaptive self-statements, and helping the child to eradicate maladaptive fear responses.


- **Art therapy** allows children to create images that express their perceptions of themselves and the world around them.
- The act of creating the art is very therapeutic.
- A concrete work of art with specific dimensions and boundaries on paper contains thoughts and issues that may have felt overwhelming to the child but are now more manageable and the child feels in control.


- **Sand play**—The tactile sensations of the water and sand mixture often cause children to become more aware of their body as a primitive form of response through the skin sensations. The sand play provides a safe and non-judgmental environment where they can more easily explore different sensations and re-awaken senses that may have been dulled due to the trauma. Hopefully over time, children will allow themselves to experience sensations that could trigger traumatic memories stored in body tissue.
- Gillespie adapted the techniques of sand play so more sand and water were used. This made the child become more physically involved by pushing their hands and arms into the sand and feeling they are part of the substance. Getting the child physically involved in the play is important in helping the therapist work with the client to resolve issues that stem from bodily abuse.
- The constant sensations that the child receives from the sand help them to begin to experiment with different body forms, body memories, and bodily sensations and feelings.

22. Greenwald (1998) Lit review & clinical description Trauma

- While the client focuses on trauma related memories and symptoms, they are instructed to follow the therapist’s finger with their eyes as it moves rapidly from side to side.
- After each (approximately 30 seconds) set of eye movements the client is asked to recall images, thoughts, emotions, or any physical sensation that occurs during the period of recall and eye movement.
- Similar techniques are used in EMDR for adults as well as adolescents and children.
- Research has shown that EMDR can be effective with children and may work faster in children than adults.
| 23. Griffith (1997) | Description of treatment model | SA |  • **Play therapy** uses the natural medium of play to help the child express themselves and release emotional distress.  
  • The therapeutic relationship is emphasized and the importance of therapist’s empathy and support of the child as they make changes and grow. The play therapy room and props all allow for extensive symbolic expression that is ideal. |
  • In beginning it was made clear to everyone in the group that all of the children had experienced sexual touching however the therapists were careful to not discuss explicit details of anyone’s abuse experiences.  
  • Each 90 minute session began with expressive play activities that used arts and crafts, puppets, role playing, stories, and group activities.  
  • Next the group moved to sit at a large table where they had a snack and talked about worries, feelings, and responses of their family and others. This activity was done to help the children begin to be able to talk about these things and for some children prepare for being present in court.  
  • Therapists also brought up relevant themes to talk about such as the responsibility of the perpetrator for the sexual abuse, and the child’s own responsibility for their behavior toward others. |
| 25. Haen (2005) | Clinical description, case example Trauma (from events of Sept 11th in NYC) |  • Metaphors were used in **group therapy** to contain the anxiety of the children, and themes were used that were central to the children’s experiences.  
  • In general there are two phases of treatment when working with people who have experienced mass disaster and terrorism, the acute crisis stage and the working-through phase. Each stage requires unique interventions.  
  • In the acute stage the therapist’s main concern is to minimize distress and mobilize the client’s ability to protect themselves.  
  • Psycho-education is often an important element of this phase used to clarify misconceptions about the traumatic experience and prepare children and their families for the possible resulting symptoms.  
  • The working-through phase occurs at different times depending on the clients, for many of the children he worked with concerning September 11th were not able to reach this phase for many months.  
  • The children needed to feel safe first before they could use the group therapy format to help them work through the trauma. |
| 26. Heiman & Ettin (2001) | Case study/clinical description, N=7 | SA |  • Goals of groups include: 1) share, ventilate, and validate feelings related to abuse, 2) develop assertiveness and protective skills, 3) develop age appropriate behaviors, improve social skills, and reduce sexualized behaviors, 4) improve impaired self and body image, 5) correct cognitive distortions, 6) resolve issues related to guilt, blame, shame, and responsibility, 7) work through feelings about the abuser and other people’s reactions to abuse, 8) improve ability to get help and support and prepare children for court, and 9) reduce symptoms and practice more effective coping skills.  
  • Each session had a topic and some sessions in combination addressed a particular topic. These topics in the order that they occurred were: 1) creating a safe place, 2) solidifying the group identity and uncovering abuse impact, 3) self disclosure and sharing of one’s abuse experience, 4) discharge of abuse-related feelings, 5) defining and clarifying rights, 6) clarifying issues of blame and responsibility, 7 & 8) developing age appropriate behaviors and assertive skills, 9) feelings towards offenders, 10) letting go: putting the trauma in |
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<tr>
<th>Author</th>
<th>Source Type</th>
<th>Group</th>
<th>Description</th>
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| Herman (1997)| Individual case study| SA                           | - Videos of traditional fairy tales are used in drama therapy to provide an appropriate context for the expression of covert sexual themes based on the child’s previous sexual abuse.  
- Provide toys and dolls for the child to use in creating and acting out dramas.  
- Fairy tales contain metaphors that the abused child can use to distance themselves from painful material.  
- The child’s creativity provides the therapist with insight into their unconscious.  
- Children can easily dramatize characters and situations from their own life to create dramas using stories.  
- Covert sexuality themes within fairy tales increase their usefulness in the treatment of sexually abused children.  
- Suggests using a combination of drama and storytelling techniques within the framework of video fairy tales to address issues.  
- The therapist uses themes and typical characters in fairy tales to help the child reveal their abuse. |
| Hill (2006)  | Description of treatment model | SA                           | - This therapy program was influenced by the theories and methods of filial therapy where parents are trained how to use non-directive play therapy techniques and be the therapist for their child.  
- One difference between the specific therapy method used in this study and filial therapy is that instead of training parents to actually be the therapist for their child, the aim was to work with the parents and the children at the same time.  
- This change allowed the parents meet with the therapist without their child as preparation for the session. These discussions gave the therapist a chance to acknowledge the significant impact the sexual abuse had on the parents and included a wider group of people to support the parents. The therapists also had a chance to observe and model therapeutic approaches for the parents. |
| Johnston (1997)| Secondary source, literature review | Abuse including SA           | - Puppets used in play therapy are effective because they provide information about the child’s emotional and symbolic world and allow the therapist to support the child in expressing and exploring their traumatic issues.  
- Anatomical dolls can also help SA children explore their experiences and issues using a safe and familiar toy. Dolls allow for spontaneous expression of emotions, sexualized play as a way to gain mastery and control over abuse, and the opportunity to gain information from the therapist concerning appropriate sexual behavior and prevention skills. |
| Jones (2002) | Clinical description, theory, and instructions to set up therapy program | SA                           | - Group play therapy is effective at reducing isolation by learning that others have similar experiences, developing supportive relationships with group members, and learning through watching others.  
- Group play therapy uses aspects of play therapy in that it is a non-directive approach that allows children to address issues at their own pace that helps abused children be in control and feel empowered.  
- Often times children who have been abused can’t describe their experiences due to their lack of cognitive development, but they can do so through play.  
- Play offers a way to express experiences, feelings, and beliefs that are too overwhelming to describe in words. |
When conducting individual or group play therapy sessions it is important that play materials are chosen that will facilitate creative and emotional expression, keep them engaged, and allow for play that is expressive and exploratory.

- Props such as telephones, sunglasses, therapeutic stories, puppets, sand play, nursing bottles, dishes, and utensils can be particularly helpful when working to help traumatized children address the trauma in some way.
- See article for specific activities addressing specific themes and specific behavior interventions

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<tr>
<th>31. King et al. (2000)</th>
<th>Quantitative randomized control study, N=36</th>
<th>SA</th>
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<td><strong>Child-alone cognitive-behavioral group therapy</strong> generally consisted of first an initial assessment of the child's issues, explanation of the rationale for the program, goal setting, and information concerning child sexual abuse and an explanation of PTSD based on the theories of CBT.</td>
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<td>The rest of the 20 sessions focused on teaching coping skills to help with troubling memories of abuse and feelings of guilt and anxiety, relaxation training, behavioral rehearsal, and cognitive therapy.</td>
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<td>In addition the children were taught to recognize and think about their self-talk when they are in anxiety producing situations, and learn how to use more positive self-talk that was emphasized through visual picture materials.</td>
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<td>Therapists taught the children to use more assertive behaviors that moved into exposure exercises that included imagination, drawings, role-playing, writing stories, and discussion.</td>
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<td>If one of the children would begin to feel anxious or scared during an exposure activity, the therapist would remind them to use the coping skills they have previously learned to help keep these feelings under control.</td>
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<td>The treatment ended with sessions that focused on relapse prevention, education on issues such as body ownership, touching, and the right to say no, and learning safety skills to use in response to future inappropriate sexual advance or touching.</td>
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<td>The participants in the family cognitive-behavioral treatment received the same treatment and in addition the non-offending parents participated in 20 sessions to be trained in child behavior management skills and parent-child communication skills.</td>
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<td>Case of an intervention that incorporates multiple modalities including play therapy, dyad treatment, parental involvement, case management.</td>
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<td>Repeated opportunities for interacting using socially acceptable ways of expressing feelings and needs can actually help reconstruct on a neurological level the techniques a child used for coping with stress and anxiety.</td>
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<td>Include the non-offending parent or caregiver in the treatment process because they serve to offer a holding environment that can stabilize the child and reduce their need to become hyper-aroused. Since many of these children have attachment issues it is important to include non-offending parents or caregivers in therapy.</td>
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<td>Dyad treatment can help to develop a sense of security and acceptance.</td>
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<td>Case management is essential to working with these children because there are many people including the</td>
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therapist that are involved in the child’s life and it is important that everyone is working together to most successfully help the child.

<table>
<thead>
<tr>
<th>33. Ogden, Pain &amp; Fisher (2006)</th>
<th>Theory, description of treatment approach</th>
<th>Trauma (no age group specifically discussed)</th>
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<tr>
<td></td>
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<td>• Sensorimotor approaches to treatment work from the bottom-up instead of the top-down through attending to the client’s body directly that makes it easier to address the more primitive, automatic, and involuntary functions of the brain that are connected to traumatic and post-traumatic responses.</td>
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<td>• Therapists using sensorimotor psychotherapy work to help clients engage their mind to observe the interactions between their perceptions, emotions, movements, sensations, impulses, and thoughts.</td>
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<td>• By teaching clients to notice their experiences on a body level they learn to notice their “innate somatic regulatory capacities” or resources that they can then use or can be evoked easily by the therapist through the breath or body movements (p. 267).</td>
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<td>• The therapist together with the client work on addressing the implicit aspects of the traumatic memories by making the client focus on the non-verbal residue of the trauma.</td>
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<td>• The somatic bottom-up intervention of sensorimotor psychotherapy can be combined with traditional top-down interventions to help clients to transform their trauma narrative and aid in the development of a somatic sense of self.</td>
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<td>• This integrated approach helps clients be able to regulate their physical experiences so that they feel grounded, resourced, and connected to the present.</td>
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<thead>
<tr>
<th>34. Ogden, Minton, &amp; Pain (2006)</th>
<th>Theory</th>
<th>Trauma (no age group specifically discussed)</th>
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<td></td>
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<td>• There are three phases of sensorimotor psychotherapy with trauma survivors: 1) symptom reduction and stabilization, 2) treatment of traumatic memory by overcoming fearful avoidance of these memories, and 3) work on personality integration and rehabilitation.</td>
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<td>• Phase 1: clients learn to recognize triggers, limit their access to overstimulating situations, and change orienting tendencies. These skills help them to increase their bodily awareness so they can begin to recognize warning signs of hyper-arousal and use somatic resources to cope with the situation.</td>
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<td>• Phase 2: the physical sensations, sensory intrusions, emotions, and actions that are a part of memory fragments are addressed. Clients work to “identify and embody the resources that helped them cope with traumatic events and learn to use the body to discover actions that provide a sense of mastery even with remembering those past traumatic events” (p.187).</td>
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<td>• Phase 3: the client has developed important skills, an awareness and confidence in their body, and the experience of feeling empowered towards traumatic memories. At this point, they are ready to begin working on the enrichment of their daily lives.</td>
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<td>• Clients are taught to shift their attention from the past to the present and therefore focus more internally. By developing the skill to narrow their focus, trauma survivors can assimilate information and begin to successfully integrate this information when they become hyper-aroused or overwhelmed emotionally.</td>
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<td></td>
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<td>• Survivors of trauma can be taught to expand their focus to include information outside their awareness that might provide stability for them.</td>
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|                                 |         | • Clients learn to focus on good feelings in their body and positive thoughts and images instead of
concentrating on painful feelings and traumatic activation in their body such as increased heart rate.

- Therapists work on both the cognitive and the sensorimotor level present in survivors of trauma to help them attain a higher level of integrative capacity and realization.

- Sensorimotor therapists pay attention to the communication of the body. They track the non-verbal aspects of the client’s experiences and read the body to observe persistent action tendencies and body postures. This information on the body helps the therapist to learn more about the client’s long held beliefs and emotional tendencies. The therapist communicates the most important information from their observations to the client, so that they too can be aware of their actions.

- Mindfulness techniques are used in sensorimotor psychotherapy to help the client become aware of and focus on their present internal experience in terms of thoughts, feelings, sensory perceptions, inner body sensations, muscular changes, and movement impulses.

- The therapist conducts different tasks to both gain insight themselves and help the client gain new insight into the effects of trauma, their behavior tendencies, and how they organize their experiences.

- Touch is used in numerous ways: 1) to activate nerve sensations to increase body awareness, 2) create new somatic resources, 3) make the individual aware of already present resources, 4) aid in the learning of new behaviors and postural patterns, and 5) help the client become aware of comfortable touch and their body boundaries. Still use touch with caution.

| 35. Pifalo (2002) | Exploratory study, 3 groups of participants, standard evaluation used | SA | Creating art acts as a buffer between the client and reality that they feel they can control. The client can choose to lower or raise the barrier depending on how threatening the information is for them. They are allowed to decide if they want to claim the work as their own, claim the art is just a picture, or be willing to explore issues in more depth. The client controls their art by being able to erase, paint over, tear, or fold any information that is too painful to deal with at that time. The process of creating art helps reduce anxiety and helps the client more openly discuss things that they could not do in a purely verbal session. See article for specific art therapy activities. |
| 36. Perry (2006) | Theory | Trauma | **Neurosequential Model of Therapeutics (NMT)** used for assessment and interventions for traumatized children. NMT treatment guidelines include:
- Make experiences relevant, relational, repetitive, and rewarding. Activities should match child’s developmental level of functioning
- Start therapy with easy, rhythmic and repetitive activities that help regulate the brainstem functioning and organization.
- If emotional material is present, the client’s state of mind will shift. If the shift is severe enough they can become so anxious that they are unable to process
- The number of repetitions needed to help a child learn or develop certain capacities is often very high.
- When a child feels safe their arousal level can be kept at a manageable level, then they can begin to benefit |
from traditional therapy methods.
• Benefits of early intervention are the earlier services are provided the more effective they will be, services will cost less and progress will be more dramatic.
• It is easier to change beliefs than feelings, so change won’t happen unless enough repetitions occur.
• 1x/wk therapy sessions won’t meet the needed amount of interactions so need to network with other caring adults in the child’s life to help.

| 37. Robarts (2006) | Theory, clinical description, case material | SA | • Approach was to first create a safe environment with boundaries that would allow the girl to explore her emotions.
• Music allowed therapist to work with the girl’s feelings as well as give her new experiences of these feelings and of herself as part of a relationship.
• The girl progressively felt more comfortable and through exposure to music would play, touch, and explore these sensations as they occurred as part of her experiences and life.
• Over time, the girl became tolerant and trusting and actually started to play music.
• Music therapy allowed her to develop important skills that she never gained during her abusive past.
• Music played a “vital role in helping her recover—or rather build—a bodily, emotional, and physical sense of self” (p. 264).
• See article for more specific activities |

| 38. Ross & O’Carroll (2004) | Literature review | SA | • **Cognitive behavioral therapy** techniques used with SA children usually include: 1) gradual exposure, 2) modeling, 3) education, 4) coping, and 5) body safety skills training.
• Gradual exposure aims to sever the child’s association between very negative feelings and abuse related thoughts. In theory, by repeatedly exposing the child to fearful thoughts and reminders of their abuse, they will eventually have a reduction in their level of anxiety and avoidance behavior.
• A reduction in anxiety frees the child to retrace the abusive experience cognitively and affectively under the continued guidance of their therapist and non-offending caregiver(s).
• Non-offending caregivers are included in the CBT process and are continually educated about the issues arising from SA of children and they are also taught coping skills.
• Cognitive behavioral therapists are concerned with the cognitive factors of the child such as: 1) their perceptions of the abuse, 2) the meaning they created from the abuse, and 3) their beliefs about themselves and the world around them. The therapists assess whether these key beliefs are functional or dysfunctional because this information has a great deal to do with the symptoms that they develop due to the abuse.
• CBT with abused children may include learning coping and prevention skills training.
• See article for more activities. |

<p>| 39. Rothschild (2000) | Theory, description of specific treatment method | Trauma &amp; PTSD specifically (no age group) | • <strong>Somatic trauma therapy</strong> uses the body and the following techniques to increase somatic resources in trauma survivors: 1) develop body awareness, 2) help client become aware of sensations to use their body as an anchor to the present, 3) use body arousal as a gauge to pace the therapy process, and 4) access information provided by the client’s body and body memories. |</p>
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<tr>
<th>Reference</th>
<th>Type of Source</th>
<th>Specific Treatment Method/Technique</th>
<th>Description</th>
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| 40. Rothschild (2003) | Theory, description of specific treatment method | Trauma & PTSD specifically (no age group specifically discussed) | • In somatic trauma therapy, the first goal is to help the client learn to contain and reduce hyper-arousal. This skill is called “putting on the breaks” and is important when dealing with strong possibly dangerous issues because they need to first know how to stop the therapy process when they start to become overwhelmed.  
• When a client is unable to put on the breaks while working through the trauma, hyper-arousal can be quickly accelerated that can lead to re-traumatization. Therapists must help clients recognize, slow down, and possibly stop this acceleration. This process will help clients feel that they are safe and in control. Feeling more in control often increases traumatized clients willingness to work through their traumatic memories.  
• Before the client learns to put on the breaks themselves, the therapist can try to reduce the level of arousal so that it is low enough for therapy to be successful. |
| 41. Ryan & Needham (2001) | Single case study | Trauma | • In play therapy, therapists prepare the therapy room and materials, making sure that the materials available are symbolically rich. Materials are often used that may trigger traumatic memories, and sometimes when a child has experienced one specific traumatic event, materials are placed in specific areas of the room to trigger memories.  
• Since traumatized children are hypervigilant and have high anxiety levels and difficulty concentrating, materials in the therapy room should be familiar and not overly stimulating. This allows the children to quickly make their own play themes.  
• Non-directive therapy uses cognitive processing spontaneously during sessions based on the child’s own pace, and the therapist gives age-appropriate information to the child as well.  
• The non-directive format does not encounter some of the issues such as strong negative emotional reactions because the child is able to keep their defenses that makes them feel more willing to let down their guard and expose traumatic material. |
| 42. Severe (1997) | Secondary source, principles, protocols, procedures | | • In EMDR the therapist can replace eye movements with any alternating left and right tactile stimuli such as tapping alternate hands on their legs.  
• During this process, other older disturbing memories may be triggered that are related to the memory or symptom being addressed. Need to process these memories too.  
• The eye movement process may be repeated many times and the focus for the client may change depending on their needs and feelings at that particular time. The process is repeated until the client no longer experiences disturbing imagery or any associated negative affects. |
| 43. Steele (2003) | Treatment method description (book chapter) | Trauma | • One structured trauma intervention method used in art therapy: expose clients to traumatic memories through drawing, developing a trauma narrative, and cognitive reframing.  
• Drawing can bring dissociated memories back into the child’s consciousness where they can be put into a narrative and integrated into their past, present and future life experiences. |
**Drawing activities used with this population need to relate to the main themes of trauma such as drawing “what happened” and “what the victim looked like at the time” (p.144).**

**Although drawing activities can be non-directive, specific instructions are often used to direct the creation of a story or narrative. Drawing is used to trigger sensory memories instead of to analyze and evaluate.**

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<th>Reference</th>
<th>Description</th>
<th>Condition</th>
<th>Treatment Protocol</th>
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<tr>
<td>Talwar (2007)</td>
<td>Description of treatment protocol</td>
<td>Trauma (protocol only for adults but modifications have been used with children)</td>
<td>In <strong>ATTP</strong>, clients paint on a large 22 X 29 piece of paper taped to a wall or an easel that allows them to stand, walk back and forth, and use their whole body while painting. This set up allows for the creating process to flow continually that allows for proprioception and suspension that helps to initiate dual processing or bilateral stimulation. Once a client has verbalized a traumatic memory and information concerning it, the therapist asks them to stop any thoughts or associations and start to paint. When they are finished painting they are requested to talk about the strongest emotion associated with the painting or parts of the painting. Next they are asked to come up with both negative as well as positive self-representations and cognitions for each memory and rate the validity of the positive cognitions on a scale from 1 to 7. The whole process is repeated each time on a separate piece of paper and switching which hand is used to paint until the memory has been completely worked through so that there are no longer any distressing feelings when they recall the traumatic experience.</td>
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| Tourgny & Hébert (2007) | Quasi-experimental pretest/post test, N= 13 for therapy and control & Comparative study of two types of groups, N=13, N= 29 | SA | The activities as part of a psycho-educational format consisted of group discussions, personal testimonies and stories, individual and group exercises, and lectures. The goals of both **group therapy** groups included: 1) reducing negative and traumatic consequences of sexual abuse to help client reach normal developmental level, 2) reducing social isolation, 3) reducing shame and culpability from sexual abuse, and 4) helping teenagers learn to use their individual resources and to develop skills to control the repercussions of sexual abuse. |

| Tufnell (2005) | Clinical description | PTSD | **EMDR** can be successful with children if adjustments are made to the techniques and EMDR procedures need to be adjusted based on the child developmental level. Often young children are unable to understand the standard EMDR procedures so different methods must be used to help them recall the traumatic experiences and reprocess this information. When using EMDR with children who have other complex issues beyond PTSD, other methods may need to be added to the overall treatment plan. EMDR has been observed to be most effective with treating single simple acute trauma; the effectiveness is reduced slightly as the traumatic symptoms become more chronic. |

<p>| Wanlass, Moreno | Case study of | SA | The four main objectives for the <strong>group therapy</strong> were: 1) provide emotional support from members who |</p>
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<th>Study</th>
<th>Design</th>
<th>Group Size</th>
<th>Description</th>
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| & Thomson (2006) | group N= 8-12 | | were going through a difficult time, 2) provide a place for members to work through their victimization, 3) provide a place to discuss normal developmental concerns, and 4) build skills associated with resiliency, such as improving self-esteem, developing interpersonal supports, and fostering adaptive coping strategies.  
   - The therapists aimed to provide psychotherapy for the group to address the effects of the abusive trauma as well as techniques of psych-education and group counseling.  
   - By addressing all levels of the traumatic experience in therapy, the therapists hoped to repair the negative effects of the abuse and help facilitate normal development.  
   - Due the upsetting and overwhelming nature of the issues dealt with in therapy, therapists need to provide containment and support for the members as they work through these issues.  This can be provided through establishing boundaries and providing specific structured activities.  
   - Behavioral management should be included in the therapy through reinforcement as set rules and point systems to teach respect for personal boundaries and keep groups safe.  
   - Group therapy leaders deal directly with “chaotic interpersonal interactions, intense affect, boundary issues, group defenses, and transference and counter transference reactions” (p. 312). |
| Zamanian & Adams (1997) | Theory, clinical description, case example | SA | Some therapy groups begin by giving children time to talk about any concerns, thoughts, and/or feelings related to being in the group.  
   - If issues related to trauma aren’t introduced by the group members, the therapist may directly introduce the topic through discussions in group psychotherapy.  
   - Open discussions about SA are important due to the different levels of understanding for children. Their ability to understand the abuse and their definitions of SA are often too narrow that leads them to minimize their traumatic experiences.  
   - Some therapy groups create structure by having overall goals and activities and specific goals for each meeting that are stated and explained at the beginning of the session.  
   - Conflicts between members are often inevitable, especially if the group is working with mainly boys, and therapists must be flexible and creative to appropriately using the conflicts as learning opportunities for the group.  
   - A group environment with self-disclosure by many people and positive peer support will often decrease the member’s resistance to therapy.  Interventions that build this type of environment include developing group boundaries and learning to contain uncontrolled affect. |
| 49. <www.arttherapy.org> | Theory, clinical descriptions | Trauma | Use of unstructured activities will encourage the child to use their imagination to create things of their choice.  
   - Structured activities are particularly helpful with children who are shy or withdrawn.  
   - Ask the child to draw a picture related to a specific theme such as worry or safety that is common in abused children. Another structured activity is to have the child create a safe place where they can go using their imagination when they get scared or upset. |
• Goals of art therapists with traumatized children include: 1) encourage them to share whatever they want through their art work, 2) use art activities to increase self-reliance and problem solving, 3) introduce different art materials, 4) teach new art skills, and 5) stimulate them make decisions about what to create.
• Once significant feelings and experiences are expressed make sure that the child is calm and in control before ending a session; use a closing activity or the children can help clean the space.
• See website for more activities and art materials to use.
**Appendix D: Matrix 4, DMT methods for treatment of sexually abused or otherwise traumatized children and treatment of adult survivors of trauma including childhood sexual abuse (CSA)**

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<tr>
<th>Children</th>
<th>Sexual abuse</th>
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<td><strong>Author</strong></td>
<td><strong>Level of evidence, type of study</strong></td>
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| 1. Ben-Asher & Koren (2002) | Single case study | Five year-old girl | • In DMT, the therapist can use somatic transference and countertransference to uncover early sources of trauma without verbal descriptions of the trauma.  
• During their third DMT session, the dance/movement therapist experienced physical sensations of confusion and nausea in her own body as she detected the client’s injured memory cohesion. The therapist used this information to decode the injured memory cohesion and contain the client’s extreme reactions in the next sessions.  
• The ability of the therapist to detect the transference and countertransference processes in her body, allowed her to understand the location of the young client’s “injured primary memory cohesion” (p. 28). This recognition helped the therapist initiate the process of healing and recovery from the trauma. |
| 2. D’Abate (2000) | Case studies | 5 children (8, 9, 11, 11 & 12 years old) | • D’Abate synthesized DMT with Barrett’s Stages and Levels of Treatment model to create Moving Systems Therapy (MST).  
• MST is process oriented, body-based, and uses a stages format to change children and family’s dysfunctional patterns.  
• MST is based on the concept that healing and transformation occur when the body, the systems within the body, and the system the body exists within change, allowing the person to experience life directly, become fully sequenced, and release the energy of past trauma.  
• Usually families and children that have experienced trauma are some how stuck using dysfunctional patterns. To fix the dysfunctional patterns in abused and neglected children the systems that they are a part of also need to move in the direction of recovery and change.  
• MST helps traumatized children experience a stronger sense of safety and awareness in their bodies |
MST provides workable realities and concrete challenges to children’s patterns in a way that fits with their individual development and level of understanding.


- Children all ages (cases; 5-7 years old, one 16-year-old Autism case)
- Creating a safe therapeutic container helps these children to feel safe, experience having their boundaries respected, and build trust in the therapist and the therapy process.
- Sometimes children will build actual safe places in the therapy space using props. Therapists can have everyone in the group visit each other’s place and ask permission before entering that makes the child feel empowered and safe. Children can also make drawings of their safe place as another non-verbal way of communicating.
- Stress confidentiality and have the therapist tell them that to keep them safe the therapist may have to talk to other trusted adults if they are in danger.

4. Truppi (2001) Quantitative study, N=21

- Adolescent girls (13 to 17 years old)
- Truppi proposes that DMT allows clients to first experience feelings on a kinesthetic level and then on a logical, cognitive level through verbal processing.
- DMT interventions used in the study included: 1) a balloon toss with balloons that have personal information written by the girls and shared as everyone is able to touch the balloon gently and with respect, 2) a card activity where girls choose cards with words that describe them and then express these words through movement, and 3) free dancing where girls can make movement suggestions, be the movement leader, or teach the group their personal movement sequence.
- See dissertation for more activities.

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<th>Children</th>
<th>General trauma</th>
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<td>Author</td>
<td>Level of evidence, type of study</td>
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<tr>
<td>5. Harris (2002)</td>
<td>Literature based study, application of program created by study</td>
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<tr>
<td>6. Harris (2007)</td>
<td>Case study, one group</td>
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• Harris combined western trauma treatment methods with rituals for success in helping these adolescents overcome their violent impulses and rediscover the joy of working together with others.

• Harris found that when adolescents are taught to experience kinesthetic empathy, they develop a stronger sense of safety that helps them to engage in more trusting interactions with their peers as well as counselors.

• Sessions involved symbolic expression through attunement and kinesthetic empathy to allow the adolescents to express their experiences in armed conflict and increase their awareness of being part of the broader humanity. This intervention evolved into a public performance by the adolescents based on their roles as both victims and perpetrators in war. This performance increased their reconciliation within their community.

• The DMT sessions consisted of openly improvisational dance to popular music of Sierra Leone with more structured physical exercise designed to address a psychosocial objective.

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<tr>
<th>7. Kornblum &amp; Halsten (2006)</th>
<th>Theory, clinical description, case examples</th>
<th>School age children (cases; 6-8 years old)</th>
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<td>• When traumatized children become fragmented, disorganized, distracted, it can be helpful for them to move around to music with a strong beat that helps organize them and make them feel settled and cohesive with the group.</td>
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<td>• Activities using a stretch cloth provide nurturing and pleasurable stimulation and helps reaffirm and settle body boundaries. When children pull each other on the cloth the touching of floor provides stimulation and this activity requires teamwork that develops trust and connection.</td>
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<td>• Working with traumatized children to create set beginning and ending rituals centers and grounds them.</td>
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<td>• It is critical to have the same space available every time a therapy session occurs. The trauma groups described were 60-90min 1x/wk for whole school year. Groups were closed and rarely are children added after a few weeks of therapy. This helps trust to develop.</td>
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<td>• Suggests having co-therapists due to the deep emotional material the children are working through and the possible need for one-on-one work when intense issues are triggered. Co-therapy also makes it easier to deal with issues of countertransference.</td>
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<td>• Goals in DMT with traumatized children: 1) build a sense of empowerment, 2) increase sense of safety and control, 3) increase ability to feel pleasure, 4) expand movement repertoire and increase self awareness, 5) improve ability to modulate feelings, 6) increase ability to empathize with self and others, 7) develop group synchrony, 8) link internal experiences to verbal expression, 9) increase awareness of others, 10) increase ability to self-soothe</td>
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<td>• Often in the beginning of therapy children ask why they are in the group, and feel it's taboo to talk about abuse. Therapist helps get answers from the group to answer this question that builds collaborative relationships and lets trauma themes naturally emerge. Children also help create</td>
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group rules for safety and confidentiality.

- Children need to know that the therapist can handle intense experiences and are not afraid of the child’s feelings. The therapist matching child’s intensity with movement and vocalizations shows them that the therapist is not afraid of their feelings.

- When children realize that others have similar painful experiences a bond is created that helps them begin to disclose material that can be anxiety-producing causing over-arousal.

- Techniques to work with anxiety: 1) use movement to express feelings while disclosing or as response to disclosing, 2) slow down the sharing by reminding them about confidentiality and checking in with how members are feeling, 3) use relaxation and grounding techniques (abdominal breathing, rhythmic movement), 4) develop movement-based therapeutic stories that can be used as a metaphor to help work through intense feelings

- Having a predictable routine helps children feel safe. Sessions usually have five sections: opening ritual, verbal/nonverbal check-in, movement warm-up, theme/creative movement story, snack and verbal processing.

- Use meditation to create sense of calm readiness to prepare for inner exploration (sit on pillow, light candle, wrap up in cloth). The cloth gives impulsive children something to hold on to, and provides a self-soothing tool. A cloth can provide a feeling of being held/touched without actual physical contact that can be overwhelming for traumatized children.

- Use check-in as time to discover pleasant commonalities to balance the painful experiences that children also have in common.

- When child feels too overwhelmed to verbalize they can express self non-verbally and group members with permission can mirror child making them feel understood and accepted.

- To work on impulsivity children are instructed to sit on the ground (lowering center of gravity increases impulse control), and follow the therapist in rhythmic drumming on the ground and when they are in control they can begin to drum on their bodies.

- In the warm-up section of therapy children learn to connect and be aware of their bodies, lean new skills, make behavioral choices, release tension and anxiety, connect with others, strengthen boundaries, and learn to use strength and assertion safely.

- Having children push against things such as a wall can help them channel their energy, feel empowered, and in control. Use of weight and strength can help them feel grounded and connected to their body. Pushing with sustainment helps reduce impulsivity.

- 4 B’s of self control: Breaks, Breathing, Brains, Body

- Treatment approaches:
1) Always start from a child’s strengths and accept them where they are at in the beginning of therapy, this builds empowerment and trust.

2) Acknowledge the positive instead of the negative to build health and self-esteem.

3) Use synchrony to develop attunement and group cohesion.

4) Rhythmic music and movement provides an organizing structure.

5) Using a circle formation can promote group cohesion and help children become aware of others.

6) Directive movement activities/structured activities can build skills and decrease anxiety.

7) By exaggerating/intensifying a movement or posture, recuperative movement in the opposite direction is encouraged and allows for release of held patterns.

8) Creation of individual space for each child that no one else can enter provides a safe place that can be used when the child is feelings over-aroused or threatened and this promotes a sense of safety and boundaries.

9) Use humor to connect with difficult or disassociated children and reduces anxiety.

10) Movement stories use metaphors to create distance and safety while in the therapy process.

11) Mirroring is used for creating attunement experiences.

12) To keep traumatized children in the present, questions are asked about internal sensations (tracking).

13) Using concrete techniques helps de-escalate and build self-confidence and mastery.
8. LeMessurier & Loman (2008) | Theory, clinical description, case examples | Young children (cases; 11 months-3 years old) | • Since traumatic memories are held in the body they can also be healed through the body by the use of movement and play to address areas of treatment in an integrated way.
• In DMT with this population therapists create a safe holding environment, attunement on a body level, and follow the child’s lead in their play and creative expression in addition to supporting self-regulation. In therapy children are encouraged to explore themes, label experiences, and create life narratives.
• When traumatized children are given the chance to build long-term therapeutic relationships they can perhaps be able to work through more specific aspects of the trauma through movement re-enactment and re-choreography. This in-depth work often doesn’t begin until the second year of treatment.
• Dancing and mirroring are used in DMT to help the child re-choreograph early attachment issues and progress to a higher developmental level by practicing different movement rhythms and patterns. These opportunities to move together also allow for the development of attachment and bonding.

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<th>Author</th>
<th>Level of evidence, type of study</th>
<th>Age</th>
<th>Concerns/treatment methods</th>
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| 9. Frank (1997) | Clinical description of a client in individual therapy | 31 year-old man (sexually abused at 12 years old) | • The client’s DMT was completed in four stages: 1) feeling safe, 2) fighting, 3) intimacy, and 4) parting stage.
• Each individual session began with a verbal check in to see how the client was feeling and to answer any questions or concerns from the last session.
• Next there were 30 minutes of non-verbal dance and movement exercises, followed by a verbal discussion of feeling during the movement portion.
• Ended session with a meditation that included breathing, grounding and reflection of the session.
• In the feeling stage, Frank worked to build safety and self-confidence, develop a trusting therapeutic relationship, and learn about the client.
• Activities in the fighting phases included touching exercises, exercises in balancing and pushing away in different ways, using props such as balls and pillows to release aggression or express aggression at abuser, using imagery and metaphors, and moving in different ways using different body parts.
• In the intimacy stage of therapy Frank has clients trace their silhouette with chalk on floor, then
color parts of their body that are strong, they dislike, are proud of, or produce shame. The touching exercises that were started in the previous stage can be increased to the therapist placing objects on the client’s body as they lay on their stomach and eventually the therapist can touch the client with their hands.

- In the parting stage the therapist asks the client what subject they would like to address and they also make a final evaluation of the client’s progress.
- See article for more activities.

| 10. Meekums (1999) | Qualitative, participatory, reflexive, N = 14 | Adult survivors | The need for safety throughout the therapy process was the most commonly referenced aspect of recovery in all of the interviews done with each participant in the group creative arts therapy sessions.
- Important aspects of treatment that were incorporated into the model of recovery were: 1) witnessing and being witnessed, 2) working through the dilemma of finding embodiment, 3) using the creative process as a way to unearth unconscious material, present and face this material as an image or feeling, and speak about it, 4) gaining a new perspective of oneself, and 5) laying the abuse to rest and gaining distance from these memories to move on in one’s life. |
| 11. Meekums (2000) | Theory, information on effects of CSA | Adult survivors | Creative arts therapy with this population occurs in three phases, beginning, middle, and final, and there are different activities to address the goals of each phase that use dance, art, music, or drama modalities.
- See book for specific therapeutic activities for each phase. |
| 12. Mills & Daniluk (2002) | Qualitative phenomenological study, N=5 | Adult survivors (25-48 years old) | The analysis of the interviews detailed six general themes of their experience: 1) sense of spontaneity, 2) permission to play, 3) struggle, 4) freedom, 5) intimate connection, and 6) bodily reconnection. |
| 13. Punger (2000) | Literature review, clinical examples | Adult survivors | Punger created a theoretical construct called “body-self dance/movement therapy” that was applied to adult survivors of CSA through a treatment model called “trauma-response body-self dance/movement therapy”.
- The construct is a combination of the theory and process of DMT with body-self theory.
- The treatment that is provided through this construct is developmentally based and “uses the body in movement and creativity to integrate the physical, emotional, and cognitive parts of the self” (p.57).
- Techniques are used to: 1) help the survivor metaphorically contain the parts of their body that were fragmented or incomplete, 2) teach clients how to protect and defend themselves to try and avoid exposing their bodies to the risk of emotionally decompensating, and 3) merging and empathetic connections allow the client to take on some of the therapist’s ego strength and self-esteem, explore their bodies through movement, and become aware of sensations and physical boundaries in the environment around them to help reawaken parts of their body that were cut off or made numb from the abuse. |
| 14. Valentine (2007) | Theory, clinical description, case examples | Adult survivors (cases; 25-45 years old) | Valentine’s perspective and model of treatment for women survivors of sexual abuse is to: 1) move toward a connection/reconnection with the body, 2) seek compassion and nourishment of the body-self, 3) find some pleasure and ease in moving, 4) appreciate their creativity in movement, 5) take in perceptions through the senses, 6) expand their movement repertoire to provide more options for |
coping with trauma issues, 7) discover preferred movement patterns, qualities and other defining characteristics of the self, 8) gain a sense of control over hyper-arousal, and 9) integrate physical, emotional, and cognitive expression, particularly relating to the trauma and abuse from the past.

- A DMT approach with survivors of sexual abuse is very different than with other populations. The movement can cause them to recall the danger of being noticed by the perpetrator and trigger interior sensations with flashbacks and/or very painful feelings.
- When starting DMT with these individuals always aware of their reactions. Verbalization is used more in DMT with this population than in DMT with other populations as a safety outlet.
- Accessing creativity is the beginning step to working on building self-esteem and empowerment that leads to change. DMT accesses client’s creativity that is often very well developed because they have had to be creative to survive.
- Guidelines for DMT individual and group sessions with this population include: 1) let clients have control and choice over their participation, 2) form themes for the session based on issues expressed either verbally or through movement by the client, 3) use the issues to help sequence interventions, 4) set boundaries of space and time, 5) encourage non-judgmental attitudes towards the body and movement, 6) respect defenses, and 7) provide safety and containment.
- Suggests co-therapy for groups to provide help with observation, individual work when required, and process material and countertransferences after the sessions.
- Based on the qualities of healing in group DMT identified by Schmais (1985) Valentine explains that group DMT sessions, can be very empowering and provide cohesion, vitalization, and education that can bring out repressed feelings in an environment of acceptance.
- Moving as a group can also facilitate expression where simple movements can metaphorically make powerful emotional statements.
- Movement with a group in the same rhythm and same spatial configuration stimulates identification with other women and leads to a common expression and a sense of solidarity.
- Clients may choose to use props with their movements such as scarves and paper streamers. Props allow the client to focus on an external object and moving into space outside of the body instead of focusing on internal sensations and feelings.
- DMT empowers these women to relive the traumatic experiences and use sensory input to stay connected to present. The ability to stay connected helps the client to stay in charge and protect herself where before she would freeze and become passive.
- When a client has a flashback, the dance/movement therapist helps them to quickly become more grounded by pushing on the wall or pushing into the ground with their feet.
- Valentine engages her clients in body awareness/grounding exercises by giving them statements and questions to think about in the moment such as: notice what stands out to you in the room and in your body, what are you aware of in the room, what are your senses taking in, notice the quality of what is supporting you while you sit or stand etc.
- After doing body awareness/grounding exercises the clients are asked how much they felt present during the experience.
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| 15. Gray (2001)     | Theory, single case study       | Adult victim of torture (case; 38-year-old woman) | • Gray used various interventions to help her client reintegrate physically, emotionally, cognitively, and spiritually and to help her understand the impacts of her past experiences.  
• DMT can help survivors of torture to rebuild their sense of wholeness and self, improve their interactions skills, and increase their ability to form relationships.  
• DMT techniques address the negative affect that torture has on an individuals body such as: 1) high bodily tension and problems with physical alignment due to muscular tension, 2) lack of movement skills learned early on in development, and 3), constricted breathing, body image issues, and restricted use of their kinesphere.  
• Gray cautions dance/movement therapists that working with the body can easily stimulate memories more quickly than when using words, and that since the body was directly involved in the torture, therapists need to be careful that their client doesn’t get overwhelmed.  
• Dance/movement therapists use props that include balls, stretch bands, and scarves to break down the therapy process into smaller steps and create a better pace for recovery.  
• Breath can also be used in a similar way to props and clients learn to expand their breathing and reduce their tendencies to hold their breath, breath shallowly, breath rapidly, or appear to not be breathing at all that are skills they have developed to protect themselves from feeling. When working on expanding the breath therapists have to again be careful to not overwhelm their clients by introducing uncomfortable sensations too quickly.  
• It is a very complicated decision whether or not to use touch in therapy particularly with clients of this population and those who are from a different culture with different rules about touch. Using touch to create the sensation of pressure helped the client to make connections to the resources her body provided as well as helped her to be able to make full movement sequences instead of fragmented movements.  
• Use therapy room as container to contain or ground the client during DMT.  
• See article for specific activities. |
| 16. Holloway (2006) | Literature based study          | Adult victims of trauma                  | • During DMT, the therapist needs to have various skills to support safety and containment because the body-based nature of DMT can bypass body-based defenses and lead to an overwhelming experience of emotions that can re-traumatize the client. |
| 17. MacDonald (2004)| Single case clinical description| Adult victim of physical, emotional, SA  | • In DMT MacDonald helped create a safe place that would provide security as the client began to tell her story.                                                                                                                |
Telling stories is an important part of the therapeutic process for clients with PTSD because this disorder consists of the inability to integrate upsetting experiences into one’s memory. The goal of therapy with these clients is to help them acknowledge these experiences without being re-traumatized. Traumatic memories shouldn’t simply be uncovered but should also be modified and transformed through narratives. Work on body level issues specifically by using therapeutic structures such as naming and affirming parts of the body, and becoming aware of parts that had become numb while breathing into all parts of the body. When troubling or distressing sensations arise, help client relate these sensations back to the client’s story and put them in context. Another therapeutic structure was creating a timeline where certain places represented specific traumatic events in her childhood. The client would choreograph her story as she moved along the pathway. In DMT the therapist should use their own body because it is an important therapy tool. The therapist can use their body to connect with tensions and emotional states in the client, and feel the client’s struggles in their own body. Work with client to help them be able to move freely without fear and move in new ways that helps them become more expressive. Address the effects that trauma has had on a client’s perceptions of themselves and the world around them. As a client with PTSD begins to re-experience their traumatic experiences on a physical and emotional level, it is essential that the therapist make sure that they do not become re-traumatized. This is done by keeping the client physically and emotionally in here and now.

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<td>Participants reported how the therapist’s non-judgmental interventions had pushed them to go deeper into their issues. The group structure provided support and helped them to realize that they were not alone in their experiences that reduced feelings of guilt and shame. The interventions helped them to be more sensitive towards their body and more self-confident in their bodies as well as more aware of their bodies that helped them more openly express their needs and feelings. They became more aware of their boundaries and body language. The therapist explained that she needed to start the therapy process using a slow, careful, and non-dance oriented approach. Since these women had either rejected and/or blamed their bodies or viewed them as non-existent and lacking emotion, most of the DMT focused on: 1) become aware of the functional aspects of the body and body parts and accept them, 2) become aware of own movements and how these can be related to thoughts and feelings, 3) let the body express itself through improvisation, and 4) be able to verbally express experiences in movement to integrate and accept the emotional aspects of experiencing.</td>
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| 19. Lumsden (2006) | Theory                           | All victims of trauma | • The complex nature of trauma symptoms requires complex therapies such as DMT. DMT is a complex therapy in that it incorporates the body, emotional and aesthetic expression, social interaction, symbol, and metaphor.  
• The aspects of dance and improvisational movement provide ways to work through trauma on two different levels, the poeitic and the cathartic.  
• Both of these levels of therapy are important when working with traumatized clients because it is essential that the therapist help their client to heal these aspects of the self to reduce the risk of retraumatization when working through the trauma.  
• DMT has the resources to work with non-verbal aspects of an individual by using the body (activation, relaxation, sensory, motor) and the “embodied self”, and working with the affective self through qualities of feeling or Efforts.  
• In DMT clients can also work on non-verbal aspects through the use of breathing, focusing, and relaxation, using techniques to work with cross-linking right and left hemispheres of the brain (like EMDR), and clients can work with abstract movement qualities without having to link them to a specific purpose, narrative, or relationship until they feel comfortable doing so. |