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Nicole Krzeminski

Lesley University, nmkrzeminski@gmail.com

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Self-Applied Touch to Promote Self-Regulation in Adolescent Males with Problem Sexual

Behaviors: Development of a Method

Capstone Thesis Project

Lesley University

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Nicole Krzeminski

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Thesis Instructor: Catherine Borbotsina, LMHC, LCMHC, ATR-BC

Abstract

Adolescents who have experienced problematic attachment relationships in infancy often have difficulty with self-regulation and therefore may cope using destructive means such as harmful sexual behavior. Self-regulation is the ability to calm the mind and body and manage emotions appropriately. Dance/movement therapy (DMT) may be a beneficial treatment tool for adolescents with problem sexual behaviors (PSB) to teach self-regulation techniques that may have not been developed due to early traumatic experiences. Self-applied touch is a DMT intervention that may assist individuals with self-regulation that was missed during critical developmental periods. This Capstone project implemented a self-applied touch warm-up with six adolescent males with PSB at the beginning of Relapse Application group sessions over three weeks. This researcher was curious about the effects the self-applied touch warm-up had on the participants' behavior in the remainder of the verbal group session. The collected data showed that the warm-up assisted some of the participants with self-regulation while it did not help others. It is possible that participants who did not use self-applied touch for self-regulation were unable due to social norms or their traumatic histories. Treatment programs for PSB may benefit by including DMT approaches in the curriculum as long as the DMT intervention is catered to the populations' needs.

Keywords: self-applied touch, self-regulation, dance/movement therapy, problem sexual behavior, adolescence, attachment

Self-Applied Touch to Promote Self-Regulation in Adolescent Males with Problem Sexual Behaviors: Development of a Method

Adolescents with problem sexual behaviors (PSB) may have difficulty with self-regulation due to problematic attachment relationships in infancy (Creeden, 2009; Felizzi, 2015; Piqueras-Ramos, 2016). For the purpose of this Capstone project, self-regulation is defined as an individual's ability to calm the mind and body and manage emotions appropriately according to the demands of the environment. Infants rely on their caregivers to protect and interpret stimuli for them, assisting them in regulation of emotions (Tortora, 2006). Slowly through caregiver-child attunement, children no longer rely on external assistance and are able to internally regulate the cues on their own (Betty, 2013). However, when infant and caregiver interactions are repeatedly ineffective and the caregiver is not attuned to the infant, the child is often unable to develop the ability to self-regulate (Betty, 2013). These children may then compromise their lack of self-regulation with maladaptive behaviors as a need for arousal such as substance use, bodily harm, or in the case of this project, sexual stimulation (Seoane, 2016).

Many treatment programs for PSB use cognitive behavior models such as the Relapse Prevention model, but they fail to integrate the neurological impact of early trauma and attachment issues (Creeden, 2009; Creeden 2013). Verbal therapy interventions such as the Relapse Prevention model are an important part of the curriculum for PSB treatment because they are concrete, evidenced-based, and have been known to assist individuals in changing offending thinking patterns (Kahn, 2011). Surveys identify cognitive-behavioral therapy approaches as the best treatment approaches for PSB (Creeden, 2013). However, due to the highly sensitive material used in Relapse Prevention models and trauma-informed work, Creeden's (2013) developmental approach to treatment argued to attend to early developmental

tasks first such as attunement, attachment, and body awareness before moving to higher levels of developmental tasks. Therefore, it may be beneficial to provide self-regulation interventions in combination with the verbal therapy interventions (Creeden, 2009). Creeden (2009) argued that PSB treatment should include movement-based arousal control interventions due to the stimuli and topics that might trigger anxiety. It is important that individuals regulate emotions before engaging in anxiety-producing discussions. Seane (2016) contended:

Clients in [a hyperaroused] state during a therapy session would be socially unavailable to the therapist because, from a psycho-neurobiological perspective, they would remain oriented toward immediate survival rather than toward relational and cognitive understanding of their individual psychology or behavior. (p. 23-24)

Therefore, a self-regulation movement-based warm-up may assist adolescents with PSB in lowering arousal levels, thus assisting them in engaging appropriately in verbal therapy groups.

Furthermore, movement interventions facilitate the ability to explore traumatic experiences due to individuals having difficulty verbalizing the events (Goodill, 1987). Goodill (1987) discussed that harmful experiences happen on a body level and therefore the trauma is apparent through the body's movements. Van der Kolk (2016) explained that trauma can cause areas of the brain to shut down that register sensations in the body. Bringing awareness to the body through movement and touch can assist these individuals in processing the traumatic experiences (van der Kolk, 2016). Additionally, movement interventions may be able to help reshape neurological pathways that were compromised during critical developmental periods (Berrol, 2006; Creeden, 2009). Current research suggests that dance/movement therapy (DMT) techniques can be used to promote self-regulation in individuals who have experienced abuse or problematic attachment (Betty, 2013; Goodill, 1987; Seane, 2016; van der Kolk, 2016), though

researchers are only beginning to explore the use of DMT with individuals with PSB (Piqueras-Ramos, 2016). One DMT intervention used to promote self-regulation is the use of touch, which is the focus of this Capstone project.

Touch can assist individuals who have experienced trauma in rebuilding trust, connection with the body, and self-regulation (van der Kolk, 2014). Van der Kolk (2014) wrote, “the most natural way that we humans calm down our distress is by being touched, hugged, and rocked” (p. 217). This need for touch is instinctual and begins in infancy. Seoane (2016) discussed that touch is an influential component of the caregiver’s role to help the infant regulate through external means, which influences the infant’s ability to self-regulate in the future. Dance/movement therapists can use touch to assist individuals in reorganizing their ability to self-regulate (Seoane, 2016). However, as Matherly (2014) and Willis (1987) discussed, there are legal and ethical concerns regarding the use of touch in DMT. These concerns include dependence on the therapist, sexual transference and countertransference, and traumatic re-experiencing. Because of these concerns, Seoane (2016) created a self-applied touch intervention that was aimed to assist dysregulated individuals in becoming more in tune with their own bodies and to self-soothe in the absence of a caregiver. Due to the sexual concerns and trauma histories of adolescents with PSB, a self-applied touch DMT intervention may be helpful in assisting this population with self-regulation.

The current Capstone project uses self-applied touch to assist adolescent males with PSB in self-regulation in the treatment setting. All of the participants had problematic attachment relationships or traumatic experiences in early childhood. Therefore, it is possible that their abilities to self-regulate were compromised. These adolescents are expected to regulate their emotions appropriately in their school, treatment, homes, and community. Group treatment at the

partial hospitalization program is composed of primarily verbal interventions using the Relapse Prevention model through a trauma-informed approach. Participants often have difficulty sustaining their attention and remaining calm in verbal therapy group sessions. It is possible that this is due to their heightened emotions stemming from the highly sensitive material. Thus, this researcher created a self-applied touch warm-up for this population to precede verbal interventions. This Capstone project observed the effects the self-applied touch warm-up had on the emotions and behaviors of the participants during the Relapse Application group session. This researcher hypothesized that the self-applied touch warm-up would assist the adolescent males with PSB in self-regulation for the remainder of the Relapse Application group session.

Literature Review

The following section outlines and summarizes some of the current literature available regarding attachment, self-regulation, PSB, and DMT.

Attachment

Attachment theory suggests that the caregiver-child relationship in infancy is pertinent to a child's development (Blau & Reicher, 1995; Tortora, 2006; van der Kolk, 2014). Early theorist John Bowlby emphasized the impact this relationship during infancy has on the child's future relationships and self-concept (Broderick & Blewitt, 2015). Because infants cannot function on their own, they rely on their caregivers to assist them in interacting with the world around them. These early years are crucial for developing skills such as self-regulation and pro-social behavior (Kenny, Blacker, & Allerton, 2014).

Ainsworth and her colleagues (as cited in Broderick & Blewitt, 2015) studied attachment through the strange situation test, in which one-year-olds were observed while being separated and reunited with their mothers. These responses were categorized into three patterns of

attachment styles. Later, researchers Main and Soloman (as cited in Broderick & Blewitt, 2015) created a fourth category. The strange situation found that the majority of babies are securely attached, meaning that they show distress when separated from their mothers and greet them happily upon their return. Babies with secure attachment may tolerate more separation, knowing that their mothers are secure bases. Anxious ambivalent babies appear stressed with their mothers, showing high distress when their mothers leave and acting angry when they return. They are often preoccupied with their mothers and do not explore on their own after separation. The third category is avoidant attachment in which babies appear unemotional during separation and reunification with their mothers. Many avoidant babies do not cry when the mothers leave and they ignore them when they return. Anxious ambivalent and avoidant attachment styles are also known as insecure attachment. The final category that was later studied is disorganized-disoriented attachment. Babies with this attachment style show contradictory behaviors, approaching the mother when stressed and also avoiding her when she approaches. There is a strong link between disorganized attachment and maltreatment in children (Broderick & Blewitt, 2015). The contradictory behavior may reflect the child's reaction to the parent who is both the source of security and the threat. Infants who do not have a secure attachment relationship with their caregivers often have long lasting implications, including the inability to self-regulate appropriately (Tortora, 2006).

Self-regulation. Literature suggests that self-regulation is learned through caregiver-child interactions in infancy (Blau & Reicher, 1995; Tortora, 2006; van der Kolk, 2014). Blau and Reicher (1995) and Tortora (2006) emphasized that the infant's earliest interactions with the world are through the physical body, using his senses to relate to stimuli. Immediately after birth, parents pay attention to the infant's physical signals, ideally interpreting them to help him feel

comfortable and safe: “it is the job of the parents and caregivers to help explain, protect, and introduce children to all of the actions and experiences they are having in their surrounding world” (Tortora, 2006, p. 41). When the caregiver is able to interpret the child’s experiences through the process of mismatch (failed responses) and repair (successful responses), the child is able to learn how to regulate his own emotions (Tortora, 2006). Van der Kolk (2014) discussed that caregivers help regulate the infant’s physical state. When the infant is in sync with the caregiver, the infant’s heart rate and breathing are steady and he has a low level of stress hormones (van der Kolk, 2014). This sense of safety through the secure caregiver relationship allows the infant to develop the ability to regulate his emotions on his own.

It is problematic when an infant cannot rely on a caregiver to interpret stimuli because the child is unable to learn self-regulation during this important period of development. When the interactions between an infant and his caregiver are repeatedly ineffective, the child has difficulty developing an organized view of the world or sense of well-being (Blau & Reicher, 1995). Infants who experience abuse or neglect “learn that terror, pleasing, and crying do not register with their caregiver” (van der Kolk, 2014, p. 115) which can lead to a feeling of helplessness. Children who do not have secure attachment relationships still develop coping styles to get their needs met (van der Kolk, 2014). Children with avoidant or anxious ambivalent attachment are still capable of maintaining relationships but may be out of touch with their feelings or feel anxious later in life. Children who experience disorganized attachment have difficulty feeling safe. They typically trust no one or, conversely, become affectionate with strangers (van der Kolk, 2014). The need for attachment continues throughout one’s life. If the individual is unable to form healthy relationships, he will seek out other ways to gain the attention of others such as breaking the law, family feuds, or hurting others (van der Kolk, 2014).

Furthermore, Berrol (2006) postulated that these early interactions impact neural development. She studied the way mirror neurons are activated through empathetic identification with another person. Schore (as cited in Berrol, 2006) discussed that visual stimulation between a caregiver and infant through mutual eye contact can increase dendritic connections in the infant's brain. This neurobiological maturation is facilitated through early caregiving interactions during which the caregiver attunes to and mirrors the infant's movements. Active engagement in mirroring between the caregiver and infant is essential for creating a normal attachment schema (Berrol, 2006). These preverbal patterns allow the infant to internalize mutuality, impacting the child's empathic process and social cognition (Berrol, 2006). Schore (as cited in Berrol, 2006) argued that if this attunement was missed in the infants' early life, the limbic system, which controls expression and regulation of emotion, may be compromised.

Offending behaviors. It is possible that problematic childhood attachment relationships are connected to offending behavior (Kenny, Blacker, & Allerton, 2014; Felizzi, 2015). Kenny, Blacker, and Allerton (2014) argued that insecure and disorganized childhood attachment influences offending behavior due to an inability to learn appropriate self-regulation techniques and social skills: "The child's relationship with the primary caregiver is the most important mediator of the impact of personal characteristics (e.g., temperament, intelligence, sociability) and social inequalities on early child development" (p. 441). The attachment relationship provides the foundation for developmental challenges. When the child's needs are not met early in life, he may compromise other skills such as empathy, self-reflection, and pro-social skills (Kenny, Blacker, & Allerton, 2014) which could lead to hurting others. While Kenny, Blacker and Allerton (2014) discuss juvenile offending and delinquency, they do not specifically address adolescents with PSB.

Felizzi (2015) hypothesized that insecure attachment was related to sexual offending, but found through self-reports of participants that it was not directly correlated. However, it is possible that the participants' self-reports did not accurately represent their caregiver relationships. Instead, the researcher found that the strongest predictor of sexual offending status was caregiver instability due to moving or homelessness (Felizzi, 2015). Although the attachment relationship was not the strongest predictor, the sexual behaviors were influenced by early caregiving. Felizzi (2015) discussed that the family and home life of a juvenile sex offender should be explored further. While Felizzi's (2015) study did not find a correlation between attachment relationships and PSB, he argued that "the observation of an unstable parent or caregiver who is sexually and physically abusive, engages in illegal acts, and is emotionally abusive toward intimate partners may serve as a powerful model for the impressionable child" (p. 651). Unstable parental behaviors may be one predictor of PSB. Further research should continue to look at attachment relationship and PSB.

Treatment

Due to stunted neurodevelopment from the trauma occurring to individuals with PSB (Creeden, 2009) as well as the highly sensitive material covered in PSB counseling, it may be beneficial to use a multimodal approach in treatment for PSB. Movement interventions, including the use of DMT, can be a way to increase self-regulation in those who have experienced trauma and problematic attachment (van der Kolk, 2014). Movement could be used in combination with verbal approaches to assist individuals with PSB with self-regulation and left-brain processing (Creeden, 2009). The following paragraphs examine neurodevelopment implications, movement interventions, as well as DMT interventions that promote self-regulation.

Neurodevelopment considerations. Creeden (2009) discussed the way trauma and attachment impacts neurodevelopment and its implications for treating PSB. Teicher et al. (as cited in Creeden, 2009) found that the limbic system is negatively affected by trauma history, noted by increased levels of activation in the amygdala and smaller volume in the left hippocampus. This part of the brain is responsible for regulating heart rate, blood pressure, and verbal and context-related memory. With these deficits in mind, Creeden (2009) outlined a treatment model for PSB that integrated trauma and attachment research. He suggested that arousal control interventions be used, interventions should help clients with executive functioning, and the focus on clients' traumatic experiences should be intertwined with their abusive behavior. Furthermore, due to language difficulties from the lack of left hemisphere development, adolescents may have difficulty processing language and therefore would benefit from a multimodal approach incorporating music, movement, kinesthetic, verbal, and visual techniques (Creeden, 2009). PSB clients may be able to better express their needs through movements rather than words. Some movement and DMT interventions are described below.

Movement interventions. Van der Kolk (2014) suggested yoga as an intervention for those who have experienced trauma to help them to become more aware of their body's needs and to foster self-regulation. He stated: "simply noticing what you feel fosters emotional regulation, and it helps you to stop trying to ignore what is going on inside you" (van der Kolk, 2014, p. 275). Van der Kolk (2014) conducted an eight-week study with female adults in which he compared a yoga intervention to dialectical behavior therapy (DBT) treatment. He found that yoga significantly improved arousal problems in PTSD and improved the subjects' relationships to their bodies while DBT did not affect the subjects' arousal levels or PTSD symptoms. When using yoga, van der Kolk (2014) emphasized the subjects' connections to their breath and

fostered mindfulness through observing the body. Van der Kolk (2014) then used yoga as an intervention to assist one of his traumatized clients with becoming more aware of her needs and her ability to verbalize her trauma. Van der Kolk (2014) wrote, “we do not truly know ourselves unless we can feel and interpret our physical sensations; we need to register and act on these sensations to navigate safely through life” (p. 274). Yoga may allow clients to notice their physical sensations and therefore can help them regulate their needs.

Similarly, Beltran et al. (2016) studied the use of yoga with African-American adolescent boys who had experienced trauma. The yoga-based psychotherapy group used a combination of breathing, meditation, and poses over 14 weeks. The combination of trauma-informed treatment, yoga, and psychotherapy was intended to increase safety and personal boundaries, self-awareness, self-soothing, self-regulation, and competency for participants (Beltran et al., 2016). These participants continued treatment with their primary therapists in addition to attending the yoga group. Participants’ self-reports did not show significant changes in behavior, however parents reported that their sons’ family functioning, interpersonal strength, and overall strength improved. It is possible that the adolescent boys were unable to accurately self-reflect due to childhood trauma restricting the ability to express anxiety and fear (Beltran et al., 2016). Beltran et al. (2016) suggested the use of yoga in combination with verbal psychotherapy. Van der Kolk (2014) and Beltran et al. (2016) both used yoga as a way to connect with one’s body and self-regulate, however, these were not formal DMT interventions.

Dance/movement therapy interventions. Dance/movement therapy (DMT), as defined by the American Dance Therapy Association, is the “psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual” (FAQs, 2016). This researcher uses DMT as her primary modality to assist clients in becoming aware of the

mind-body connection and to emphasize the importance of nonverbal communication. Unlike van der Kolk's (2014) and Beltran et al.'s (2016) yoga interventions, DMT is a psychotherapeutic approach that combines verbal and nonverbal expressions rather than using movement and psychotherapy as separate interventions. Dance/movement therapists are trained to allow clients to express their needs through their bodies, interpret their movements as part of the told story, and use kinesthetic empathy to assist clients in their therapeutic processes. There are many DMT interventions that can be used with clients, with only a select few described below.

DMT may be beneficial to use in combination with other psychotherapeutic approaches for children who have experienced early trauma due to these events happening in the preverbal developmental period of the child's life. Goodill (1987) emphasized that harmful experiences that happened during the preverbal period of life will not be able to be expressed verbally, but can be seen through the body and explored nonverbally. In outlining a case study with a child named David who was abused and neglected in infancy, Goodill (1987) described, "it was only when any expectations for David to verbalize his emotions were discarded that his movement therapy started to progress" (p. 62). She was able to work with David's early movement patterns to help him progress through developmental stages that were missed due to his abuse. Goodill (1987) described four other case studies in which DMT assisted the children in ego strengths, trust, self-expression, self-awareness, and communication. She used DMT as her primary intervention to assist her traumatized clients in expression.

Likewise, Betty (2013) created a DMT treatment approach to support self-regulation for maltreated children, specifically in residential treatment centers. She described a four-phase two-hour module, for a total of eight hours, in which direct-care professionals offer body-based

therapeutic group interventions to clients. Betty (2013) began by creating safety in the group through breath work and movement patterns that emphasized growing and shrinking. Phase two focused on emotional awareness through rhythm. The third phase emphasized strengthening internal emotional coping through rhythm and role-play story telling. Finally, the last module promoted external expression management through attunement and mirroring. Betty (2013) did not conduct this intervention but hypothesized that this four-step module would assist mal-attuned children in self-regulation.

Another DMT intervention that can be used for self-regulation is self-applied touch (Seoane, 2016). Infants rely on external regulation from caregivers and over time through attuned caregiving, self-regulation can become internalized. When an infant's needs are not met due to mal-attuned caregiving, children may be unable to learn to regulate their emotions on their own during this crucial developmental period (Seoane, 2016). Some children may attempt to self-regulate by other means such as self-injury or harmful behavior:

The development of harmful self-touch as a way to self-regulate is adaptive because one who learns not to rely on external regulation or has not learned effective self-regulation finds in self-injurious behaviors a convenient and seemingly effective, albeit dysfunctional, means to self-regulate.” (Seoane, 2016, p. 30)

Therefore, implementing a DMT intervention using self-applied touch can reteach healthy and appropriate touching and help individuals reshape their ability to self-regulate (Seoane, 2016). Seoane (2016) outlined a five-phase intervention (assessment, mindful containment, attunement, nurturing, integration) using self-applied touch with adults. Clients would use their own hands physically on their origins of dysregulation. Although the intervention was not implemented, the

intention was that self-applied touch would assist adults with mindfulness, self-awareness, and arousal regulation (Seoane, 2016).

Currently there is little research that examines the use of DMT with individuals with PSB and therefore it is an important field of study to expand upon. One qualitative study explored the benefits of using DMT with males with PSB (Piqueras-Ramos, 2016). In fact, the researcher studied the link between attachment, PSB, and DMT. Piqueras-Ramos (2016) argued that DMT can offer an approach that is able to expand upon and support other therapies. Through a literature review and an examination of a single client, the researcher found that DMT could be beneficial for supporting self-regulation with adolescent males with PSB. Piqueras-Ramos (2013) used DMT to increase boundaries and self-regulation for one client through individual and group DMT sessions. She used props to assist the client with his levels of anger, incorporated breathing, and guided him in gentle guided relaxation and visualizations to bring awareness to part of his body. Through the literature review, Piqueras-Ramos (2013) discovered that DMT is able to emphasize non-verbal communication, create body metaphor providing distance from emotions, target attachment work, and offer creativity. Piqueras-Ramos (2013) argued that DMT was a restorative approach that should be used alongside other group and individual therapeutic interventions. Piqueras-Ramos (2013) identified that using semi-structured interviews and direct interventions could have increased validity of her study. This current Capstone project will also examine the use of DMT as a self-regulation tool to support verbal psychotherapy interventions for individuals with PSB.

Methods

The self-applied touch warm-up was implemented with adolescent males with PSB through the following methods.

Participants

The self-applied touch warm-up was carried out in a partial hospitalization program designed to target PSB through the Relapse Prevention model. Clients in the partial hospitalization program typically participate in group therapy two times per day, five days a week. The majority of group therapy sessions utilize the cognitive behavior therapy and collaborative problem solving models. Participants in the current project included six adolescent males ranging from ages 13 to 16. Four of the participants identified as African American and two identified as Caucasian.

Problem sexual behaviors. For the purposes of the current project, PSB are defined as sexual behaviors that are inconsistent with adolescents' developmental age. These adolescents have sexually offended at least one person and receive treatment to target their sexually deviant behaviors. Two of the participants were referred to the partial hospitalization program through another mental health agency while the other four participants were referred to the program through the juvenile court. All participants engage in relapse prevention planning to assist them in making safe choices and engaging in healthy sexual behavior. Due to this population's issues with sexual behaviors, this researcher chose to avoid researcher-participant touch in the interventions. Willis (1987) noted that touch can be interpreted as sexual by a client even when this is not the intention. In order to avoid sexualization of the intervention as well as recognizing legal and ethical issues of touch in DMT, this researcher chose to use self-applied touch with this population.

Procedure

The procedure consisted of carrying out the self-applied touch warm-up with the adolescent boys as well as the collection of the data. This researcher, who also served as the

group facilitator, conducted the self-applied touch warm-up at the beginning of the weekly Relapse Application group session. The warm-up was carried out three times over three consecutive weeks. A detailed description of the self-applied touch method and the data collection are described below.

Self-applied touch warm-up. The warm-up was conducted from a seated position. The lights in the room were turned off. The duration of the warm-up lasted roughly 10 minutes. At the beginning of each session before the warm-up began, the participants were asked to describe how they were feeling using one word. The self-applied touch intervention then began with instructions from this researcher for participants to close their eyes or lower their gaze, place their feet flat on the floor, and find a comfortable position in their chairs. They were then asked to place one hand on their own chests and the other hand on their own stomachs. The participants simultaneously inhaled three deep breaths in through their noses and exhaled out through their mouths with the guidance of this researcher. Participants were then instructed to place their hands on the top of their heads, rubbing in small circles and lightly brushing their scalps. They were then instructed to gently touch their faces and ears, then the front and back of their necks. This researcher continued to instruct participants to apply pressure and touch to their body parts, working their hands slowly from head to toe, including the shoulders, arms, hands, fingers, chest, upper back, stomach, lower back, hips, front and back of thighs, knees, shins, calves, and feet. As participants touched each body part, they were asked to become aware of any sensations they felt and recognize the feelings that arose. They were told to add extra pressure to body parts that held tension or felt uncomfortable. After the full body self-applied touch was completed, this researcher instructed participants to again lower gazes or close their eyes and place one hand on their own chests and the other hand on their own stomachs. The group took three slow breaths

with this researcher's instructions to complete the warm-up. Participants were asked to open their eyes and lift their gazes and the lights were turned back on. Participants were again asked to describe how they were feeling in one word. At this time, this researcher asked the participants about their thoughts regarding the warm-up. During the remainder of the session, the participants engaged in an activity from a Relapse Prevention workbook regarding negative thinking patterns related to the participants' sexual offenses. At the end of the one-and-a-half-hour session, the participants verbalized their feelings one final time.

Data collection. This researcher recorded the one word responses from before the warm-up, after the warm-up, and at the end of the session in a journal. She hoped that the participants were able to verbalize their emotions in reaction to how their bodies felt in that moment. This researcher allowed the participants to choose their own words, as opposed to providing emotion vocabulary, to allow for freedom of expression. She compared their one-word responses from before, immediately after, and at the end of session. This researcher categorized the one-word responses into negative, positive, and calming emotions to help make the distinctions when the emotions shifted. Ideally, the participants' emotions before the warm-up would be different after the warm-up, noting a positive or calming change. This researcher also noted participants' statements during the warm-up and their comments during the discussion in the journal. These comments indicated the participants' like or dislike of the intervention and added insight into whether the participants made connections to self-regulation or awareness of the body. Additionally, this researcher recorded observations of the participants' behavior throughout the session in a journal after each session. She noted the participants' interactions with peers, ability to focus on the presented material, and overall affects and moods. The goal was that if the warm-up assisted the participants in self-regulation, the self-regulation would help them focus on the

presented verbal material. The data collected assisted this researcher in better understanding the effects of a self-applied touch warm-up for a verbal therapy group session with male adolescents with PSB.

Results

The information collected from the six participants by this researcher is described below, outlining the participants' responses each week and behavioral observations in the Relapse Application group sessions.

Participants' Responses

Week One. Five of the six participants were present for the Relapse Application group session during week one. At the beginning of the session, participants reported a range of emotions, with no significant pattern that was apparent. No participants reported a positive emotion immediately following the self-applied touch warm-up. Two participants reported a calming emotion, as described by "tired," after the warm-up was conducted. At the end of the hour-and-a-half session, three of the five participants reported a positive emotion.

In response to this researcher's questions, three participants reported that they liked the warm-up while two participants reported that they disliked it. The two participants who reported that they disliked the self-applied touch method did not fully participate in the warm-up. Some comments that were made during the warm-up included "my neck hurts," "this is too much like yoga," and "this is boring." During the discussion following the self-applied touch application, participants reported, "I liked it because I could make rhythms on my body," "boring," "I liked it," and "it was fun."

Week Two. All six of the participants were present during week two. Once again, participants reported a range of emotions at the beginning of the group. The majority of these

emotions were negative, using words such as mad and aggravated. Only one participant reported a positive emotion. Of the five participants that reported negative emotions, none of these participants reported a calming or positive emotion following the self-applied touch intervention. Only one of the participants who was feeling negative at the beginning of the session reported a positive emotion at the end of the session. He used abstract words to describe his emotions stating he felt “cloudy,” “executed,” and “upbringing” throughout the three times that this researcher checked in with him. When asked to further clarify these words, he described that cloudy felt like sadness, executed meant dead or exhausted, and upbringing signified uplifting. The majority of clients experienced negative emotions throughout the session.

When engaging in discussion regarding their thoughts about the warm-up, one participant reported that he liked it, three participants said they felt indifferent, and two participants reported that they disliked it. The two participants that did not like the self-applied touch did not fully participate in the warm-up. Throughout the warm-up some of the comments included “this is corny” and “this feels feminine.” During the discussion after the warm-up some of the positive statements about the warm-up included “it felt like a massage,” “I noticed my body is sore” and “it reminds me of how I put myself to sleep at night.” Some negative statements included “I don’t want to watch men touch themselves” and “I only did it to not get in trouble.”

Week Three. All six of the participants attended the session during week three. They all partook in the self-applied touch intervention. Similar to the previous two weeks, the emotions reported at the beginning did not follow a trend but rather ranged from anxious to enthusiastic. Immediately following the warm-up, the majority of the responses did not reveal a shift in emotions. Two participants reported that they felt calm as noted by their responses “relieved”

and “down to earth.” When participants reported emotions at the end of the session, none of them stated a positive emotion. Two participants used calming adjectives—fragile and tired.

This week, one participant reported that he liked the self-applied touch intervention, two reported that they felt indifferent, and three reported that they disliked it. During the warm-up, participants commented, “this feels like a massage,” “I did yoga last night,” and “it feels weird to touch my arm because of my scars.” During the discussion following the warm-up, the participants noted, “it felt weird,” “I don’t care, I just did it,” “it makes me really tired,” and “I only touch myself like this in the shower.” In addition to the verbal responses to the self-applied touch warm-up, this researcher noted behavioral observations.

Behavioral Observations

Week One. Despite some of the participants reporting that they did not enjoy the warm-up, in general the remainder of the Relapse Application group appeared calm and most participants were able to remain focused. Three of the participants, including one of the participants that did not fully engage in the warm-up, were able to remain on task for the remainder of the group session. They were able to engage in the discussion regarding the presented Relapse Application material and they were able to manage their emotions appropriately. These three participants were able to interact appropriately with one another, give constructive feedback, and they presented with positive affects. Interestingly, one participant that was fully engaged in the warm-up had difficulty remaining on task during the Relapse Application material. This participant was distracted and engaged in a side conversation with a participant who did not fully participate in the warm-up. They appeared positive but they had difficulty interacting appropriately with the group.

Week Two. The majority of the group members appeared frustrated or tired at the beginning of the session. Most of them had blunted affects. Their affects remained roughly the same throughout the session. During the warm-up, four of the six participants engaged in the warm-up. Two participants chose to not partake in the warm-up. These two participants had difficulty focusing in the remainder of the session. They had difficulty staying on task, talked to each other, and expressed their frustrations about their homes and the group itself. Of the four individuals that chose to participate, one was actively involved in the session and on task while the other three were not disruptive but did not actively participate in the Relapse Application material. The four that participated in the warm-up were able to interact with the rest of their peers appropriately and appeared calm throughout the session.

Week Three. At the beginning of the session before the warm-up began, all of the participants appeared to be in positive moods. They were having active conversations with one another and laughing. All of them were willing to participate in the warm-up and continued to laugh and talk with one another during it. The participant who reported that he liked the warm-up was the one who gave the most effort in scanning and touching each body part. This participant appeared calm through the remainder of the group and occasionally participated in the Relapse Application discussion. All of the participants were able to participate in the Relapse Application material. Two of the participants had high energy levels while four remained fairly calm.

Discussion

Current literature suggests that DMT interventions can assist individuals with self-regulation (Berrol, 2006; Betty, 2013; Blau & Reicher, 1995; Goodill, 1987; Piqueras-Ramos, 2016; Seoane, 2016; Tortora, 2006). Because treatment for PSB includes highly emotional topics, Creedon (2009) proposed that movement-based interventions could assist individuals with

PSB with arousal control. Therefore, this researcher anticipated that a DMT intervention could prepare the adolescents for verbal therapy groups by assisting them with self-regulation before presenting sensitive interventions. This current project used a self-applied touch warm-up to assist adolescent males with PSB in self-regulation prior to presenting Relapse Application material.

As shown in the results, the responses across participants were not consistent. Some of the participants were more receptive to the intervention and were better able to participate. One participant in particular gave his full effort all three of the weeks and appeared calm after the intervention each week. He was able to discuss body awareness and made connections to self-soothing. He discussed that he used this type of method to help him fall asleep at night. Because this participant had used a similar method on himself before, he may have felt more comfortable with the intervention. The other five participants were more inconsistent in choosing whether to fully participate in the intervention. Interestingly, emotions and behaviors did not tend to change immediately after the warm-up, however, shifts in emotions and behaviors were apparent at the end of the session. It is possible that these shifts were due to the self-applied touch warm-up or due to another factor within the session. It appeared that some participants were able to use the self-applied touch warm-up for self-regulation some weeks while other weeks it did not seem to assist them.

One positive outcome of the intervention was that it allowed some participants to become more aware of their bodies, as evidenced by statements about body parts that were sore or uncomfortable. Awareness of the body helps individuals become more present in the moment, creating mindfulness (Seoane, 2016). Seoane (2016) discussed that clients practicing mindfulness in the therapeutic setting are better able to process memories and feedback in the

session. Van der Kolk (2016) also emphasized that body awareness assists with verbalizing memories. Therefore, participants who were able to self-regulate during the intervention may have done so by bringing awareness of their bodies in the room. This is the mind-body connection that DMT aims to foster.

While some of the participants were able to use the intervention for self-regulation, others expressed disinterest in applying touch to their own bodies. It is possible that the self-applied touch warm-up in the group setting was not suitable for adolescent males due to their developmentally appropriate awareness of their peers. Social awareness and peer influence is central in adolescent years. Adolescents tend to perform and operate according to the group dynamics, conforming to group norms, roles, and expectations (Broderick & Blewitt, 2015). It is possible that the adolescents in the current project did not fully participate in the self-applied touch warm-up and showed disinterest due to wanting to conform to their peers' standards. This was apparent between week one and week two. One of the participants that showed interest in the warm-up during week one showed disinterest in week two, perhaps because the participant that was absent in week one, who is his friend, expressed disinterest during week two.

Additionally, as one of the participants proclaimed, the self-applied touch warm-up could have been perceived as feminine. Adolescent males tend to conform to masculine socialization, known as the "boy code." Broderick & Blewitt (2015) explained that "the boy code requires learning that feelings of fear, weakness, and vulnerability should be suppressed to appear brave and powerful" (p. 319). Therefore, it is possible that the participants felt uncomfortable allowing themselves to be vulnerable in front of their peers and wanted to be perceived as masculine. This intervention may be more effective when working one-on-one with an adolescent male with PSB. Other DMT interventions that do not require direct touch may be more suitable for this

population such as the use of props to create distance from the direct touch, mirroring, rhythm making, or guided visualization body scans.

It is also possible that some of the adolescents expressed disinterest in self-applied touch because of their traumatic histories. Van der Kolk (2014) discussed that trauma patients lose touch with their bodies, sometimes being unable to feel sensations or whole areas of their bodies. Trauma can even cause depersonalization, which allows the self to become detached from the body, unable to experience pain or pleasure (van der Kolk, 2014). Furthermore, Beltran et al. (2016) discussed that boys with a history of trauma may experience dissociation and a restricted ability to express emotions. Van der Kolk (2014) emphasized the importance of reconnecting with the body to recover from trauma, however, individuals are not always ready to do so. He stated: “noticing sensations for the first time can be quite distressing, and it may precipitate flashbacks in which people curl up or assume defensive postures” (p. 103). Perhaps the participants in the current project were unable to discover the full effects of the self-applied touch warm-up because of their difficulties facing the trauma, lack of readiness to use touch, or desire to remain dissociated. Touch is an intense sensation that may have been too stimulating at that time for the participants.

While the results showed that DMT may be a useful tool for some individuals to prepare for verbal therapy groups, the method was only implemented over a three-week period. The Capstone project placed limitations on the amount of time it could be carried out and the amount of information that could be collected. More patterns may be recognized if the project could be replicated over a longer period of time. Future studies should examine the effects of the self-applied warm-up over a longer period of time.

The literature to date suggests that movement-based interventions are useful in PSB programs to assist clients in self-regulation (Creeden, 2009; Piqueras-Ramos, 2016), however, the amount of literature exploring DMT and PSB is scarce. Therefore, this is an important topic to continue to explore. While this current project suggests that the DMT intervention self-applied touch may be a useful tool to assist some adolescent males with PSB in self-regulation, further research should continue to explore the connection between DMT and PSB.

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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