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The Use of Dance/Movement Therapy to Improve Stabilization of Trauma Responses in Survivors of Intimate Partner Violence: A Literature Review

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Abstract

Intimate partner violence (IPV) is a traumatic experience that requires trauma informed care. Because trauma effects the body and often places a survivor in a state of flight, fight or freeze, it is important that the body be involved in recovery from IPV. This includes stabilization of the body's physical responses to trauma, which is part of the first phase of trauma recovery—safety. Through a review of the literature on trauma treatment, IPV programs, and body-based therapies such as dance/movement therapy (D/MT) and somatic psychotherapy (SP), stabilization that addresses the body is found to be an important part of trauma recovery. However, little research has been done on body-based stabilization in recovery for survivors of IPV. Pulling from the literature, this paper addresses the gaps and advocates for the use of D/MT as a treatment intervention to improve stabilization with survivors of IPV.

Keywords: intimate partner violence, domestic violence, abuse, trauma recovery, trauma-informed, stabilization, safety, bottom-up, body-based, mind-body, dance/movement therapy, movement psychotherapy, body psychotherapy, somatic psychotherapy, sensorimotor psychotherapy

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Introduction

According to the World Health Organization, one in three women[1] has been a victim of intimate partner violence making it "one of the most common forms of violence worldwide" (Pill, Day, & Mildred, 2017). Intimate partner violence or IPV "refers to an ongoing pattern of coercive control maintained through physical, psychological, sexual, and/or economic abuse (by an intimate partner) that varies in severity and chronicity" (Warshaw, Sullivan, & Rivera, 2013). Whether a single incident or perpetual abuse, IPV is a traumatic experience that can result in survivors[2] developing an array of mental health concerns and trauma symptoms (Goodman et al., 2016; Herman, 1997; Pill, Day, & Mildred, 2017; Sullivan, Goodman, Virden, Strom, & Ramirez, 2018; Warshaw, Sullivan, & Rivera, 2013). However, researchers are noticing a lack of IPV agencies addressing these symptoms, so they are advocating for more trauma-informed models to be implemented (Arnault & O'Halloran, 2015; Goodman et al., 2016; National Center on Domestic Violence, Trauma and Mental Health, 2011; Pill, Day, & Mildred, 2017). This type of approach involves a specific focus on establishing emotional as well as physical safety in the survivor's body and environment, which Judith Herman (1997) describes as the first phase of trauma recovery. Safety is the number one concern when working with survivors of IPV

[1] Much of the research on this topic focuses on women as the victim and men as the perpetrator. However, it is importance to note that IPV does not discriminate based on gender, sexuality, religion, socioeconomic status, or race and effects a wide range of individuals.

[2] For the purpose of this paper, the term "survivor" will be used to identify a person who has experienced IPV, however, not everyone with this experience identifies as a "survivor."

(Arnault & O'Halloran; Devereaux, 2008; Goodman et al., 2016; Herman, 1997; National Center on Domestic Violence, Trauma and Mental Health, 2011; Sullivan, Goodman, Virden, Strom, & Ramirez, 2018; Warshaw, Sullivan, & Rivera, 2013). While much is being done to address physical safety concerns with shelters, safety planning and legal action, less apparent are the ways that address the emotional safety and mental health of IPV survivors (Devereaux, 2008; Pill, Day, & Mildred, 2017).

Because of trauma's effect on the body, more attention is being paid to treatments that take a "bottom-up" or body-based approach where the person's kinesthetic and sensory experiences are given more attention than the cognitive process (Arnault & O'Halloran, 2015; Courtois & Ford, 2013; Cristobal, 2018; Grabble & Miller-Karas, 2018; Levine, 2010; Levine & Land, 2016; Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, 2014). These approaches include an increase in awareness of the body and the specific triggers and sensations of trauma responses, which aides in grounding and stabilization of a survivor of trauma such as IPV. For this paper, I will specifically focus on the use of dance/movement therapy as a body-based approach with this population due to my scope of practice.

As a dance/movement therapy (D/MT) graduate student, I believe in the body's ability to communicate what cannot be put into words. Because we experience trauma through the body, it only makes sense that trauma processing should address the need for reclaiming a sense of safety in the body. Sensorimotor psychotherapists and dance/movement therapists discuss the use of grounding, mirroring or reflecting back and other experiences that increase the survivor's awareness of their body to create stabilization and aid them in regaining a sense of control over their body (Cristobal, 2018; De Tord & Bräuninger, 2015; Leventhal & Chang, 1991; Ogden, Minton, & Pain, 2006; Rothschild, 2000). While more consideration is being given to the use of

body-based interventions for trauma survivors, little research is being done that specifically addresses this type of trauma recovery for survivors of IPV (Pill, Day, & Mildred, 2017; Warshaw, Sullivan, & Rivera, 2013). Therefore, the aim of this paper is to address the gap and highlight the need for more research on IPV programs that address the whole body and establish a sense of emotional safety alongside physical safety.

In this paper, I will identify body-based trauma treatment approaches with dance/movement therapy theory and practices in order to advocate for the use of dance/movement therapy as an intervention for establishing safety and stabilization with survivors of IPV. The paper will begin by addressing the effects of IPV and the need for more trauma-informed treatment for survivors. Next, I will discuss the importance of the first phase of trauma treatment and the focus of this paper—safety and stabilization—and the need to include body-based approaches during this focus in treatment. Then, D/MT will be described as well as an overview of current D/MT literature with survivors of IPV. After this, D/MT will be compared with other body-based interventions that increase safety and stabilization of survivors of IPV. Finally, accessibility of D/MT and application of body-based practices in IPV programs will be discussed as well as cultural and IPV specific considerations. To close, this paper will address the gap and the need for more research focusing on D/MT and trauma-informed programs for IPV survivors.

IPV and Trauma

Cases of IPV date back to the late nineteenth century when women were being diagnosed with "hysteria" or "the wandering uterus." Sigmund Freud was the first mental health professional to write about the issue, however, he ended up withdrawing his theory to protect his reputation and the status of those families he was treating (Herman, 1997). This is an example of

the reality of silencing that happens in IPV and the power of the perpetrators. These women Freud saw were often unable to speak or form coherent sentences, but he nonetheless identified the abuse that was happening. However, the power and status of the women's husbands allowed them to continue to get away with their abuse and control until the feminist movement in the 1970s gave a voice back to the women. It was at this time that the necessary research was done to confirm the reality that, "sexual assault against women and children were shown to be pervasive and endemic in our culture" (Herman, 1997, p. 30).

As previously stated, IPV is the experience of physical, emotional, sexual and/or financial abuse on an individual by an intimate partner (Warshaw, Sullivan, & Rivera, 2013). Depending on the duration and an individual's previous life experiences, survivors of IPV can develop a range of mental health concerns that impact daily functioning. Sleep disruptions, hyperarousal, dissociation, confusion, hopelessness, isolation, flashbacks, decrease in affect regulation, substance abuse and suicidal ideation are some of the myriad of symptoms found in survivors of IPV (Warshaw, Sullivan, & Rivera, 2013). Because perpetrators of IPV exert their power and control over survivors, many also develop a conditioned fear response of immobility as an "intentional strategy used to avoid or minimize abuse that is beyond their control" (Warshaw, Sullivan, & Rivera, 2013, p. 3). Peter Levine (2010) described this kind of chronic immobility as giving "rise to the core emotional symptoms of trauma: numbness, shutdown, entrapment, helplessness, depression, fear, terror, rage and hopelessness" (pp. 66-67). Learned responses during trauma exposure can lead to secondary issues, which can then lead to problematic symptoms and medical issues such as chronic pain, substance abuse, depression and other mental health concerns.

These symptoms that have resulted from the experience of IPV have a significant impact on the mind and body. During a traumatic event, the brain initiates a protective flight, fight or freeze response in the body via the autonomic nervous system, however, the brain doesn't always recognize when the threat has been removed. In this event, signals of continued danger are sent through the nervous system, keeping the body in a defensive hyperaroused or hypoaroused state (Grabble & Miller-Karas, 2018; Lopez, 2011; Rothschild, 2000; van der Kolk, 2014). Lopez (2011) stated that, "this continued preparation for defensive action is at the core of the disturbing physical and psychological symptoms associated with PTSD" (p. 136). These disturbing physiological responses point to the body as the critical site for the focus of trauma treatment and why IPV survivors would benefit from trauma informed body-based interventions to increase their well-being and recovery.

Trauma-Informed Approach to IPV Recovery

More research is needed on the implementation of trauma-informed approaches in IPV programs to support the increasing needs of IPV survivors (Arnault & O'Halloran, 2015; Goodman et al., 2016; Pill, 2017). According to a study done by Goodman, et al. (2016) on the development of trauma-informed practices in IPV programs, "over the last 15 years, [IPV] programs have reported that program participants are struggling with more severe, chronic and varied traumatic experiences and mental health difficulties than ever before—challenges that many staff feel unprepared to address" (p. 749). When staff don't recognize or understand the effects of trauma on an individual it perpetuates the cycle of disempowerment that is a result of "the abuser's pattern of ridicule, control, and domination" snowballing with "prior community responses that have failed to help" (Sullivan, Goodman, Virden, Strom, & Ramirez, 2018, p. 564).

According to the National Center on Domestic Violence, Trauma and Mental Health (2011), "a trauma-informed approach to [IPV] advocacy means attending to survivors' emotional as well as [environmental] safety…it also means ensuring that all survivors have access to advocacy services in an environment that is inclusive, welcoming, destigmatizing, and non-retraumatizing" (p.1). Because many survivors of IPV experience poverty, homelessness, concerns of immigration status and lack of safety in their environment, advocates tend to triage these challenges as most urgent, while the trauma symptoms are less attended (Goodman et al., 2016). More programs are needed that address safety and stabilization in both the environment and the physical experience of IPV survivors' trauma symptoms.

Safety and Stabilization

Judith Herman (1997) described trauma recovery in three stages: 1) establishing safety, 2) remembrance and mourning, and 3) reintegration. This paper focuses on the first stage. It is the stage that requires the most care and attention because, "by definition, individuals who have been traumatized have been made to feel unsafe" (Courtois & Ford, 2013, p.123).

Safety in trauma recovery involves establishing safety in one's environment as well as their physical body. Environmental safety for a survivor of IPV involves intensive safety planning around the needs of the survivor. This may involve securing placement in a shelter or seeking legal help to remove the perpetrator from the home. Engaging in therapy during ongoing abuse, "can actually intensify the danger because it might threaten a controlling and insecure partner" (Courtois & Ford, 2013, p.125). Therapists and survivors must work together to create the best plan to ensure a survivor's safety. This may also include educating a survivor in order to increase their awareness of "patterns of violence" until their environmental safety is ensured (Courtois & Ford, 2013).

Because survivors of trauma often feel unsafe in their bodies, it is important to address not only their environmental safety but their somatic symptoms and emotion dysregulation by establishing a sense of safety and control of their body. Herman (1997) described the need for physical safety in the body in the following excerpt:

> Chronically traumatized people no longer have any baseline state of physical calm or comfort. Over time, they perceive their bodies as having turned against them. They begin to complain. Not only of insomnia and agitation, but also of numerous types of somatic symptoms (p. 87).

In order for trauma recovery to be successful, treatment needs to address safety in both the environment and the physical body. However, it is important when working with survivors of IPV to pace the trauma work and address emotion regulation and managing of somatic symptoms once the survivor is living in a safe environment. Barbara Rothschild (2000) explains that "resolving trauma implies releasing the defenses that have helped to contain it. If one is still living in an unsafe or traumatic situation, this will not be possible or advisable" (p.87). There is much to consider when approaching trauma treatment with survivors of IPV and the establishment of their safety.

While agencies supporting IPV survivors are addressing survivors' needs for environmental safety through legal advocates and shelters, more needs to be done so that survivors feel safe and in control of their bodies as well. As Sullivan and colleagues (2018) stated, "unless these underlying traumas are dealt with, survivors may not be able to achieve increased well-being" (p.564). Arnault and O'Halloran (2015) added that, "even after so many years away from the [IPV] abuse, trapped energy and incomplete cycles could explain why they have difficulty achieving the zest, vigor, vitality and social engagement that they had been

searching for" (p.30). More IPV recovery interventions are needed that can address trauma symptoms on a sensorimotor level in their body.

Dance/Movement Therapy and IPV

There are a number of therapeutic practices being implemented for trauma recovery that take a body-based approach to treatment. One of these is dance/movement therapy or D/MT. D/MT, as defined by the American Dance Therapy Association, is "the psychotherapeutic use of movement to promote emotional, social, cognitive and physical integration of the individual" (FAQs, n.d.). Though it has been practiced since the 1950s, few articles involving D/MT and trauma have been published and even fewer regarding survivors of IPV. In 1991, neuropsychologist, Fern Leventhal and dance/movement therapist, Meg Chang, published the first theoretical framework for using D/MT with survivors of IPV which focused on themes of immobilization. It wasn't until 2008 that Christina Devereaux, another dance/movement therapist, published a case study of her work with a family exposed to domestic violence. When it comes to D/MT and IPV research in the United States, these are the two articles that have started the discussion for application of this type of work. However, more support is needed from other dance/movement therapists and professionals in the field doing similar work to increase this advocacy. For example, there are more D/MT articles being published that involve trauma processing as well as with specific populations such as sexual abuse, child abuse and survivors of torture (Bernstein, 1995; Cristobal, 2018; Gray, 2011). These articles discuss core D/MT concepts that align with the trauma recovery model for survivors of IPV which includes, "(a) establishing emotional safety, (b) restoring choice and control, (c) facilitating connections, (d) supporting coping, (e) responding to identity and context, and (f) building strengths" (Goodman, et al., 2016). The following will outline the D/MT core

concepts addressed in the literature as well as other body-based interventions for trauma recovery and stabilization.

Body-Based Treatment for Stabilization

Body-based therapists and many other trauma theorists believe that addressing a survivor's experience in their body is a crucial part of trauma processing and recovery (Arnault & O'Halloran, 2015; Courtois & Ford, 2013; Cristobal, 2018; Grabble & Miller-Karas, 2018; Levine, 2010; Levine & Land, 2016; Ogden, Minton, & Pain, 2006; van der Kolk, 2014; Rothschild, 2000). Because trauma manifests itself in the body, careful attention should be given to observing a survivor's body defenses and to identify signs of trauma response. For example, as Lopez (2011) described,

> Following a traumatic event, the emotion-system of the victim/witness may enter into crisis in three important ways: a loss of self-esteem and trust; the development of states of hyper or hypo-tension of the striated and smooth muscles; and an inability to ask for and accept help (p. 141).

Keira Cristobal (2018) described the following goals to be essential when approaching work with survivors of sexual abuse, "establishing safety, boundaries and stability in one's body; learning to re-establish and work on intimacy with self and others'; learning how to regulate one's emotions and accept and re-order body image; and working on expression of feelings" (p.76). However, it is important to note that not every intervention will be appropriate for every survivor and providers are encouraged to assess the regulatory capacity of the survivor at all points in their process. Ogden, Minton, and Pain (2006) stated that "monitoring hyper-and hypoarousal responses (see figure 1) becomes the barometer for evaluating the efficacy of any somatic resource explored during phase 1 [stabilization] treatment" (p.214).

As previously stated, the following section will look at body-based interventions for stabilization from the somatic and body psychotherapy lens as well as the D/MT lens in an effort

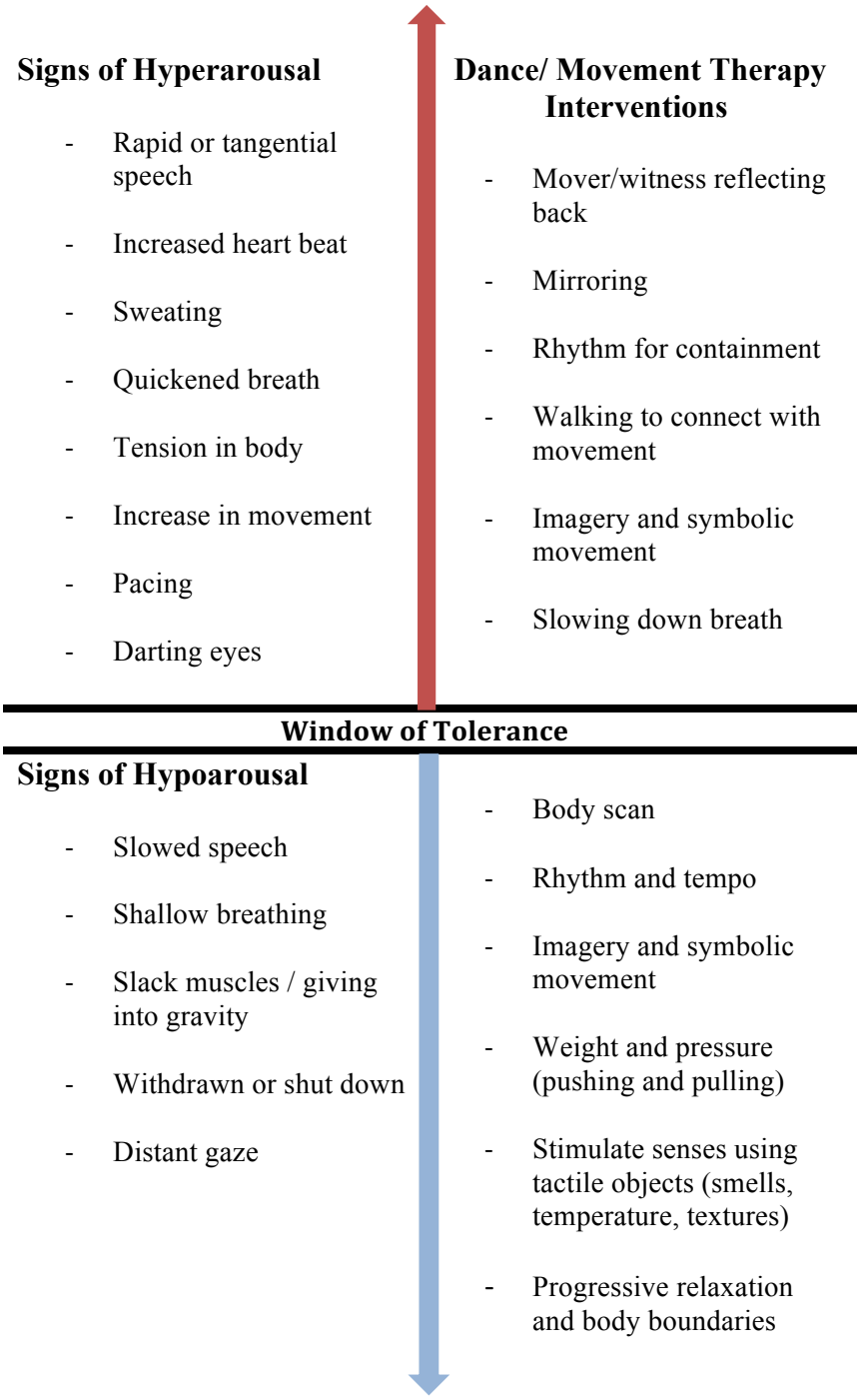

Figure 1: Body-Based Interventions for Stabilization During Crisis

to address the gap in literature on the use of D/MT for stabilization in trauma work. Somatic psychologist and dance/movement therapist, Jennifer Frank Tantia (2016) compared SP and D/MT stating they are both "based in the psychophysiological philosophy that embodied awareness is the prima facie of self-knowledge, and healing happens through experience" (p. 184). Tantia (2016) stated that both SP and D/MT providers believe that "repressed emotions and memory are held in the musculature and can be released through manipulation or expression of the body" (p. 184). This belief is at the center of body-based work and is what sets it apart from traditional talk therapy and other cognitive, top-down, approaches. While SP and D/MT are built on these similar core beliefs, D/MT stands apart due to its element of creative expression and use of movement assessment tools to observe and analyze individual and group dynamics and inform treatment.

Resourcing

In practices such as SP, the therapist focuses on increasing a survivor's *resources* which can be defined as, "all the personal skills, abilities, objects, relationships, and services that facilitate self-regulation and provide a sense of competence and resilience" (Ogden, Minton, & Pain, 2006, p. 207). An important part of this process is identifying *somatic resources* which includes the way one's body responds to internal and external stimuli (Rothschild, 2000). Somatic resources can be used to provide a sense of stability through "awareness and movement of the core of the body (centering, grounding, breath, alignment)" as well as improve interpersonal skills and social connection through "awareness and movement of the periphery (pushing away, reaching and locomotion)" (Ogden, Minton & Pain, 2006, p. 222). These are all common SP practices used to increase one's somatic resources. Similar practices are also incorporated in D/MT.

The first step in resourcing involves identifying resources already in use. Ogden, Minton and Pain (2006) described an example of a resource a survivor may already be using and why it is important to identify this defense in the following excerpt from their book *Trauma and the Body:*

> Because clients usually experience immobilizing defenses of freezing or submission as personal defects, it is important to reframe them as survival resources that helped them live through inescapable trauma. When the therapist validates clients' defensive subsystems as coping strategies that they were forced to employ, clients are encouraged to view them as capacities rather than as weaknesses and then can work with them more effectively to dismantle their chronic engagement (p. 209).

Once current resources are identified and validated in this way, additional somatic resources can be introduced through movement, mindfulness and use of observation and reflecting on the therapist's part to increase a survivor's awareness when they are utilizing a resource. For example, if a therapist observes tension in a survivor's body, the therapist can bring attention to it and invite the survivor to exaggerate this tension in order to increase the awareness of the effect of the tension response on the survivor's body (Ogden, Minton & Pain, 2006). Rothschild (2000) in her book, *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*, wrote that, "simple body awareness makes it possible to gauge, slow down, and halt traumatic hyperarousal, and to separate past from present" (p. 101). This separation can aid in reminding the survivor and their body that the trauma they endured is in the past and the flight, fight and freeze defenses do no need to fire as regularly.

Tracking

Another similarity between somatic psychotherapists and dance/movement therapists is that both are "trained to track (notice, identify and follow) movement in a client's body in different ways" (Tantia, 2016, p. 187). In authentic movement, a concept utilized in D/MT, the role of the therapist is referred to as the "witness" and the client as the "mover" (Adler, 1999). As the witness, a dance/movement therapist can identify signs or shifts in arousal states (see figure 1) and bring a survivor's attention to those changes. This can be helpful in the stabilization process as survivors are learning to become aware of their sensorimotor and kinesthetic responses. Ogden, Minton, and Pain (2006) described that, "learning how to sense and identify internal sensations such as feeling tense, cold, heavy, numb, or tingly can help clients recognize the precursors to traumatic arousal and plan alternative coping strategies" (pp. 218-219). This type of awareness can also improve regulation as it "can be useful in helping to recognize that no emotion or somatic state lasts forever. Learning to follow the ebb and flow of somatic sensations may reinforce the idea that emotional states also ebb and flow" (Rothschild, 2000, p. 96).

The literature recommends that if a client is in a hyperaroused or destabilized state (see figure 1), "it may be more effective to work exclusively with movement rather than sensation, such as standing or pushing" (Ogden, Minton & Pain, 2006, p. 219). In addition to that, Rothschild (2000) describes the importance of careful pacing when increasing awareness of sensations as it can be more triggering for a survivor to maintain awareness of a sensation for an extended period of time. Rothschild (2000) recommends that if "anchoring is the goal, body awareness inquiry must be fairly quick paced- not speeding, but not allowing the client to focus on any one sensation for very long" (p. 108). This quick body scan is recommended for

survivors in states of hypoarousal (see figure 1) where small increases in body awareness are encouraged for centering in the present moment.

Mirroring

A core belief discussed in D/MT and literature on other body-based therapies is the use of movement and mirroring to increase a person's awareness of their body and internal experiencing (Fischman, 2016; Levine & Land, 2016; Ogden, Minton, & Pain, 2006; Rothschild, 2000). For survivors of trauma, it can be difficult or painful to pay attention to the body, especially if one has built up the defense of disconnecting with their body as a way to survive the trauma they endured. That is why Levine and Land (2016) describe how "quotidian movement such as walking, breathing, or waving an arm can increase mobility, bridge the connection between mind and body, and help clients develop a healthy relationship with their body and movement" (p. 342). Engaging in these smaller movements can support a survivor's reconnection to their body and ultimately increase their ability to regulate.

Another way to increase this awareness is through mirroring. Cristobal (2018) describes mirroring as "reflecting or echoing a client's movements, emotions, or intentions (via mirror neurons), which are implied by a client's movements for the purposes of increasing empathic attunement and enhancing emotional understanding between client and therapist" (p. 82). It communicates to the survivor that they are being seen and thus supporting a feeling of containment while engaged in movement. Ogden, Minton, and Pain (2006) describe the SP approach to mirroring and mirror neuron activation in the following statement: "as clients observe their therapist demonstrating a somatic resource, they experience it in the brain as if they were executing the same action and experiencing the same emotional effect, essentially "rehearsing" the movement themselves" (p. 214). Because dance/movement therapists are

trained in movement analysis and assessment, they are able to recognize subtle movements or changes in the body and bring a survivor's attention to them through interventions such as mirroring, supporting an increased awareness and a contained reconnection to the experience of one's body.

Increasing Movement

A similar theme to the SP intervention of expanding one's resources can be found in the D/MT literature on trauma recovery—the expansion of a person's movement repertoire. According to dance/movement therapist, Amber Elizabeth Lynn Gray (2001), "movement repertoire provides an indication of one's expressive capacity, which reflects one's emotional range" (p. 34). This is especially resourcing for a survivor of IPV who may experience a sense of immobilization or entrapment in their bodies as a defensive trauma response (Levine, 2010). Levine and Land (2016) describe this type of defense in the body as "sheltering" and stated,

> Sheltering the body is not healthy for clients because it shelters the emotional world and their capacity for connection. By liberating their bodies, clients open themselves physically and emotionally to connecting with others. D/MT can help give ownership of space back to the individual (p. 340).

Levine and Land (2016) go on to describe that this increased range of movement expression can be an indicator that enough safety has been established. That being said, stabilization in the body needs to be introduced with careful pacing as movement can trigger past trauma that may be stored in the body and require further resourcing and pacing to be released with therapeutic benefit (Devereaux, 2008; Levine & Land, 2016). Once initial defenses are broken down and resources are established, increased movement can be explored. Movement in this way can support survivors in experiencing a sense of power as they regain control over their

body and embody a state of action (Leventhal & Chang, 1991). At the beginning stages of recovery, increased movement exploration can be supported through use of imagery and symbolic movement such as moving like an animal, embodying the experience of floating on water or pushing a piano across the floor. This imagery provides an opportunity for survivors to experience a broader range of movement in a contained way, supporting stabilization.

Boundaries

Due to the lack of boundaries experienced within a survivor's environment and relationship, reestablishing boundaries is an important part of recovery from IPV (Cristobal, 2018; Devereaux, 2008; Ogden, Minton & Pain, 2006). As survivors are supported in D/MT sessions to reconnect with their bodies, they are able to experience and identify where their boundaries are on a physical and emotional level, increasing their sense of control and ability to regulate their emotional experience (Cristobal, 2018; Rothschild, 2000). Boundaries can be explored through movement in a number of ways. In D/MT, these interventions often involve an awareness or exploration of one's kinesphere. A kinesphere is a term used to describe "the space around the body that serves as an individual's bridge to the world" (Gray, 2001, p. 34). Cristobal (2018) described that using "spacing, facing, and pacing," dance/movement therapists are able to support a survivor in exploring their boundaries, "identify(ing) somatic signs of arousal that push them beyond their edge, and signs that keep them in their window of tolerance" (p. 80). The experience of the body as a container is another part of establishing boundaries that is discussed in the literature. This might involve "tightening the large muscles of the body…giving a feeling of less permeability and strengthening awareness of the ability to both "keep things in" and "keep things out"" (Ogden, Minton & Pain, 2006, p. 231). The embodied experience of exploring boundaries through tension and release to feeling one's feet on the floor or stretching a

hand out as far as the body allows, brings a deeper awareness that can support a survivor of IPV in their trauma recovery.

Rhythm and Grounding

Through drumming, stomping the feet, clapping the hands or tapping on the body, rhythm in D/MT sessions is often used as a way to create structure and establish feelings of control (Levine & Land, 2016). Cristobal (2018) describes that rhythm, especially when repeated, "elicits a sensation of safety; rhythm is regulating" and it can be used to support body awareness during the beginning stages of treatment when survivors may have more challenges accessing kinesthetic sensations (p. 83). Dance/movement therapists often utilize rhythm in group settings as a way to observe dynamics and "relational patterns" (Fischman, 2016, p. 40). Rhythm also supports grounding through the use of weight, tempo and increased awareness of the body and its connection to the earth. Dance/movement therapists, Patricia de Tord and Iris Bräuninger (2015) stated that rhythm is grounding because "experiencing rhythm builds up orientation in the here and now" (p. 17). Connection and grounding through rhythm can support a survivor's sense of control, increased awareness and social connection in a contained way.

Discussion

While D/MT can be beneficial for improving stabilization in the body of survivors of IPV, it is important to note the following limitations and considerations for application of this therapeutic practice. To start, most IPV agencies do not have a dance/movement therapist or other body-based therapist on staff. Because IPV agencies are the most accessible form of treatment for survivors, it is recommended that trainings be made available to IPV advocates that teach techniques on how to address stabilization in the body when the survivor may be moving out of their window of tolerance (see figure 1). Dance/movement therapists are trained in

observation and assessment of these shifts in arousal states and appropriate ways to respond through body-based interventions. However, key elements of observation can be taught alongside techniques such as breathing and grounding experiences to support a survivor during a trauma response. These elements can also be useful for advocates and other staff in stabilizing their own responses to the survivor's experience and allowing them to remain grounded in moments of crisis.

Another consideration involves the therapeutic relationship, which is a crucial element in the healing process. This relationship can prove challenging with a survivor whose "primary relationships are sources of profound disillusionment, betrayal, and emotional pain" (Courtois & Ford, 2013). Courtois and Ford (2013) described how the therapeutic relationship, "might be met with a range of emotions, such as fear, suspicion, anger, or hopelessness on the negative end of the continuum and idealization, hope, over dependence, and entitlement on the positive" (p. 134). It is in these situations where the therapist must create an environment of support, "openness and empathic attunement with limits and boundaries… determined by the clients needs, personal resources, and the respective attachment styles of therapist and client" (Courtois & Ford, 2013, p. 136). D/MT creates this environment through thoughtful pacing and use of movement, music and creative expression to process that which cannot be put into words. Dance/movement therapists are also trained in self-reflection through kinesthetic seeing (Tortora, 2006). This skill provides the therapist with the necessary tools to listen and observe their own kinesthetic experience as well as the survivor's in order to make informed decisions regarding treatment, pacing and offer insights on the dynamics of the therapeutic relationship.

Another important limitation to be aware of is the challenge of seeking any type of therapy while still involved with the perpetrator. This can be dangerous for survivors in a

number of ways. Knowledge, or even suspicion, that a survivor is telling someone else about the abuse can result in more violence or threats against the survivor. Warshaw, Sullivan, & Rivera (2013) described another risk for survivors with children who may seek therapy when they stated, "it is not uncommon for perpetrators to use the women's help-seeking against them, claiming that they are too "mentally ill" to effectively care for the children, which may discourage women from seeking treatment" (p. 3). Therapy while still in an abusive relationship can also be dangerous without necessary safety planning. For example, "accessing feelings while having to remain on guard when returning home… and any intervention that enhances survivors' sense of self-esteem and empowerment may require additional safety planning strategies" (Warshaw, Sullivan, & Rivera, 2013, pp. 16-17).

Careful pacing is another important element of therapy with any survivor. Rothschild (2000) described this pacing as,

> Safe driving involves timely and careful braking combined with acceleration at the rate that the traffic, driver and vehicle can bear. So does safe trauma therapy. It is inadvisable for a therapist to accelerate trauma processes in clients or for a client to accelerate toward his own trauma, until each first knows how to *hit the breaks*—that is, to slow down and/or stop the trauma process—and can do so reliably, thoroughly, and confidently (p. 79).

Pacing in this way is crucial in avoiding retraumatization[3] of a survivor and maintaining an improved sense of safety.

Because IPV effects a wide range of populations, there are important cultural and socioeconomic considerations to name. Warshaw, Sullivan and Rivera (2013) stated,

[3] Pacing in this way is also necessary in avoiding secondary or vicarious trauma as a therapist.

> It is critical to remember that culture influences how individuals define and experience mental health and mental illness, the types of stressors they encounter, the decisions they make in seeking help, the symptoms and concerns they present to clinicians, and their coping styles and sources of social support. Recognizing these concerns and addressing them directly can help reduce some of the barriers survivors face in obtaining help (p. 17).

This also includes a survivor's socioeconomic status and accessibility to treatment. Ongoing therapy may not be accessible to a survivor with limited funds, lack of child care or insurance needed to cover treatment (Warshaw, Sullivan, & River, 2013). That is why much of IPV treatment is being done through agencies that provide more accommodations to meet the varying needs of survivors.

Warshaw, Sullivan, and Rivera (2013) summed up some of the important considerations when working with survivors in the following excerpt;

> Incorporating an understanding of the dynamics of IPV is essential for responding to the types of issues IPV survivors face related to safety, confidentiality, coercive control, parenting, custody, legal issues, immigration, social support, and economic independence, all of which influence how a survivors is affected by the abuse, [their] ability to participate in treatment, and [their] response to treatment. (Warshaw, Sullivan, & Rivera, 2013 p.16)

With all this in mind, one must remember there is "no single treatment model that will fit the needs of all" survivors (Warshaw, Sullivan, & Rivera, 2013 p.18). That is why it is necessary to work in alliance with the survivors to create a plan that best meets their needs based on their experience and accessible resources and supports.

Considerations for Implementation

Considering these limitations, the following is a proposed D/MT program that is structured in a way that creates a contained environment for a group of survivors to address their trauma symptoms and engage in interventions specific to improving stabilization in the body. This program might be implemented in a residential IPV program where survivors' environmental safety is already stabilized through the IPV agency along with access to other necessary resources. During this program, a training would be offered to advocates working with survivors on the importance of including the body in trauma processing. This training would address ways advocates can utilize observation tools to asses critical shifts in a survivor's arousal state (see figure 1) as well as basic interventions such as grounding and breath work to stabilize the survivor back into their window of tolerance. These skills can also be used by advocates to support their own regulation in moments of crisis. The program would be facilitated over 8-10 weeks in a group format since much of the research on IPV survivors supports fostering connection with other survivors in an effort to decrease previous isolation (Leventhal & Chang, 1991).

Figure 2 provides an outline of core components of a program and what the necessary pacing might look like. Due to the number of considerations when working with this population, it will be important to gather information regarding each participants' history and experience before engaging in group programming. First, psychoeducation would need to be facilitated on the impact of trauma on the body and the resourcing that happens in response. This will be important for normalizing the survivors' individual experiences. Then, stabilizing techniques are slowly introduced and practiced as well as careful reconnection to the body through movement and tracking. Initial tracking of sensations will be explored using art, mindfulness and a

provided list of physical sensations. Ogden, Minton & Pain (2006) stated, "developing a precise vocabulary for sensation helps clients expand their perception" and supports deeper processing (p. 219). Multiple weeks will be given to tracking and slowly increasing survivors' awareness of their sensory and kinesthetic experiences with grounding techniques being utilized throughout. As the individuals in the group become reintegrated with their bodies, movement explorations that encourage interpersonal connection and support empowerment, such as using rhythm, boundary setting and mirroring, will be explored. Finally, proper time will be allotted for termination of the group.

Core Components	Goals
Psychoeducation	Increase awareness of trauma's effect on the body and the defenses/ resources one can develop
Grounding	Practice and identify grounding techniques to be utilized throughout program
Tracking	Increase body awareness through tracking body sensation using art and mindfulness
Foster Trust & Group Cohesion	Increase interpersonal connection, increase body awareness and support empowerment and further grounding through use of rhythm
Tracking with Movement	Increase body awareness through mindful movement
Boundaries	Identify and establish boundaries through movement exploration
Integration of Skills	Increase interpersonal skills and empowerment through explorations of mirroring
Termination	Provide necessary closure and support empowerment

Figure 2: Dance/Movement Therapy Program Proposal for Body-Based Stabilization from IPV

This program has been designed based on the literature and has not yet been implemented with this population. Because stabilization of a survivor's trauma response takes time and careful pacing, as previously mentioned, this program is meant to act as the starting point to secure a sense of stabilization before continuing with more steps toward deeper recovery. As the program is implemented, appropriate assessments and evaluations will need to be conducted throughout and involve responsiveness to group participants at each point in the activities to ensure survivors are feeling contained, safe and supported.

Conclusion

Through a review of the literature, this paper aims to address the gap regarding resources for body-based trauma recovery for survivors of IPV and advocate for the use of D/MT as an effective treatment intervention for trauma stabilization with survivors. Findings showed D/MT can be used to improve trauma stabilization in IPV survivors through increasing emotional regulation, body awareness, interpersonal connection, empowerment, grounding, and identifying and establishing boundaries through various body-based interventions. The literature supports the use of body-based approaches to improve stabilization in trauma survivors (Arnault & O'Halloran, 2015; Courtois & Ford, 2013; Cristobal, 2018; Grabble & Miller-Karas, 2018; Levine, 2010; Levine & Land, 2016; Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, 2014) and agrees that more research needs to be done on program development and implementation that addresses these needs (Arnault & O'Halloran, 2015; Goodman, et al., 2016; Grabble & Miller-Karas, 2018; Levine & Land, 2016; Pill, Day, & Mildred, 2017).

Future research is needed on the use of D/MT with survivors of IPV as well as implementation and evaluation of programs that address the trauma symptoms of an IPV survivor through improving stabilization in the body's trauma response. This paper helps lay a

foundation for future research, trainings and program implementation. It also offers potential implications for the use of D/MT to increase safety and stabilization with other trauma survivors. Overall, more is needed to ensure proper resources and programs are established that address the stabilization of IPV survivors' trauma responses.

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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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