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Observing, Understanding, and Treating Disordered Attachment Patterns:

A Dance Movement Therapy Perspective

Capstone Thesis

Lesley University

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Dance Movement Therapy

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Abstract

This literature review discusses attachment patterns formed in infancy and its implications for early childhood development and later life functioning. The impact of attachment patterns on the quality of a child's interpersonal relationship, body action tendencies, emotion regulation and fear response patterns are explored. The attachment process as facilitator of these patterns is revealed as well as the disruption of healthy and adaptive attachment bonds as predictors of psychopathologies. Healthy neuropsychobiological development is shown to be facilitated by the nonverbal communications between the right brains of the mother-infant dyad. Mismatching in these nonverbal communications are shown to thwart the child's development. Nonverbal observation skills, assessment, and treatment utilized by dance movement therapists are discussed as uniquely tailored to the early intervention and treatment of attachment trauma.

Keywords: dance/movement therapy, attachment patterns, child development, trauma

Introduction

Deepening our understanding of infant development is one of the “fundamental objectives of science” (Schoore, 1994, p. 3). It is the very beginning of an organism’s life that will set the stage for “every aspect of its internal and external functioning throughout the lifespan” (p. 3). With this in mind, we will discuss how our early attachment patterns impact later life functioning in the context of interpersonal relationship, body action tendencies, and regulatory capacity. We will see that “the disruption of healthy and adaptive attachment bonds may lead to “the many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional detachment” (Bowlby, as cited by Levy & Johnson, 2018, p. 2). Observation skills and assessment of attachment patterns will be discussed along with treatment interventions.

It is understood that “what happens from the fetal period until two years of age creates the blueprint that influences every system in the body,” (Levine, 2007 p. 34) and that the damaging impact of disordered attachment is the root of developmental trauma. According to Levine (2007) “prenatal infants, newborns, and very young children are the most at risk to stress and trauma due to their undeveloped nervous, motor, and perceptual systems” (p. 8). This thesis will further explore the importance of a caregivers’ ability to attune to and respond to the needs of their child during this critical period of development, and that, as Levine (2007) pointed out, “those who are traumatized in the fragile period during infancy carry the burden of trauma’s imprint as a lifelong struggle...” (p. 17).

Literature Review

Attachment styles developed in infancy are understood to impact development across the life span (Siegel, 2012; Ogden, Minton & Pain, 2006). This critical inquiry examines multiple perspectives in development theory to articulate different attachment styles and further understand the impact of trauma on attachment. This informs dance movement therapy practice in the observation of early

attachment relationship, assessment and treatment across the life span. DMT as an effective modality in the treatment of disordered attachment is discussed and compared with evidence based, attachment focused, psychotherapeutic and body-oriented modalities of treatment.

Attachment

Siegal (2012) explained attachment as, “an inborn system in the brain that evolves in ways that influence and organize motivational, emotional, and memory processes with respect to significant caregiving figures” (p. 91). He stated that this attachment system, being genetically programmed to ensure survival, “motivates” infants to seek proximity and establish communication with primary caregivers. Such communication is nonverbal, emotional, and establishes attachment patterns.

The attachment patterns developed in infancy usually remain, “relatively stable throughout the life span” (Ogden, Minton & Pain, 2006, p. 46). Furthermore, secure attachment is an achievement that will provide “the primary defense against trauma induced psychopathology” (Ogden, Minton & Pain, 2006, p. 47). It is understood that securely attached infants cry upon separation from their mother, often try to go after her, and they will initiate contact upon her return. They are observed reaching up to be held or molding their bodies to their mother. Once they are reassured by her presence and her gestures, they tend to return to play (Siegal, 2012).

Adults who have secure attachment histories will “seek proximity to others with no avoidance or angry resistance and can tolerate relational frustrations and disappointment” (Ogden, Minton & Pain, 2006, p. 48). They will seek comfort from others, are able to participate in coregulation, and they also possess the ability to self regulate. Body - action tendencies in this group tend to include congruence between body movement actions and internal emotional states.

Levine (2007) stated that “without the playful interactions of an unstressed, mentally attuned, and emotionally stable caregiver, healthy attachment simply does not occur” (p. 36). Mothers with histories of

abuse and trauma face a particular challenge in establishing secure attachment with their infants. Mothers with histories of abuse have been found to be more likely to engage in abusive behaviors toward their children than mothers without an abuse history (Bert, Guner & Lanzi, 2009). Intergenerational transmission of abuse occurs when parents adopt their parents' abusive style and repeat the cycle with their own children. The continuation of the pattern has been coined the "cycle of abuse" (Ben Shlomo & Ben Haim 2017). Walker, (1999) points out that "survivors of abuse enter parenthood at different points in the resolution of their own suffering and depending on this and on the extent of the effects, they experience parenting differently" (p. 282). A lack of resolution of parents' traumatic experiences may lead to "confusion and disorganization in the process of bonding between themselves and their children" (Doucet & Rovers, 2010, p. 97). A mother's stress level has also been shown to impact her ability to recognize and respond to her baby's cues (Sossin & Birklein, 2006).

Mothers of insecure-avoidant infants "actively thwart or block proximity seeking behavior of the infant, responding instead by withdrawing or even pushing the child away. These mothers appear to have a general distaste for physical contact except on their terms and may respond to the infant's overtures with wincing, arching away, or avoiding mutual gaze" (Ogden, Minton & Pain, 2006, p. 48). Behaviors observed in infants who have anxious/avoidant attachment patterns include unemotional responses to their mothers. They may fail to cry when their mother leaves and are indifferent when their mother returns to the room (Siegal, 2012).

As adults, children with insecure-avoidant attachment patterns often develop a "dismissive stance" towards the importance of attachment in relationship. They may "distance themselves from others, undervalue interpersonal relationships, become self-reliant, and tend to view emotions with cynicism" (Ogden, Minton & Pain, 2006, p. 49). An adult with insecure-avoidant attachment may "withdraw under stress and avoid seeking emotional support from others.... they may find dependence frightening or

unpleasant and avoid situations that stimulate attachment needs” (Ogden, Minton & Pain, 2006, p. 49). Persons with insecure-avoidant attachment patterns’ body action tendencies will vary. They might have high or low muscular tonicity and/or rigidity. Adults with this attachment pattern might be more comfortable with defensive movements rather than reaching out or moving toward. They may avoid eye contact, withdraw or become passive and demonstrate an overall lack of emotion. A sensorimotor approach to therapy with these clients would include, “somatic interventions that strengthen interactive regulation and social engagement (reaching out, seeking proximity, eye contact.) (p. 49).

Mothers of infants with insecure ambivalent attachment patterns are observed to be “inconsistent and unpredictable” (Ogden, Minton & Pain, 2006, p. 48) in their responses to the infant. They may either over-arouse, stimulating the infant when they need to down regulate, or fail to help the infant engage when stimulating interaction is needed. These mothers are often preoccupied with their own emotional needs and fail to respond to the infants’ needs. With such inconsistency in availability they may at times allow proximity and closeness and sometimes not. The child’s somatic and affective communications are often not met with an appropriate, reliable or consistent response (Ogden, Minton & Pain, 2006).

Insecure ambivalent attachment patterns are observed in infants that appear wary or distressed. They may stay close to their mothers and appear preoccupied with her, but they will not take comfort in her presence. They become very upset when their mothers leave but are not put at ease by their return and fail to explore upon reunion. They appear to simultaneously seek renewed contact with their mothers while resisting their efforts to soothe them (Siegal, 2012).

Ogden, Minton, and Pain (2006) report that adults with insecure-ambivalent attachment histories often become “preoccupied with attachment needs, overly dependent on others, and might have a tendency toward enmeshment and intensity in interpersonal relationships, with a preference for proximity” (p. 50). Body action tendencies that develop tend to be more congruent than other attachment

patterns in terms of their emotional states and physical movements. Their behavior however is often dysregulated and uncontained. Their actions appear to be serving the often frantic need to discharge energy associated with states of high arousal rather than the achievement of specific goals. According to the authors it is essential that this population learn to regulate high emotional and physiological states. Additionally, dysregulated and non-directional movements must be replaced with purposeful directional and goal-oriented action.

Siegel (2012) explained that organized forms of insecure attachment are adaptations to the particular patterns of their caregiver's communications. Ogden, Minton, and Pain (2006) pointed out that while "insecure patterns...contain clear deficits.... they, like secure attachment, are considered to be relatively adaptive and organized and predict future capacity for more or less adaptive behaviors" (p.48). Siegel (2012) observed that children with insecure attachment are "less likely to result in compromises to mental health in later development than disorganized forms" (p. 97).

Mothers of infants with disorganized/disoriented attachment patterns are described as either frightening or frightened (Ogden, Minton & Pain, 2006). They may exhibit patterns or actions that include "looming behaviors, sudden movements, sudden invasion or attack postures (or) backing away, exaggerated startle response, retraction in reaction to the infant, a fearful voice or facial expression" (p. 51). The authors stated that this type of mother may also elicit reassurances from the child often placing the child in the position of having to take care of their own unmet needs. In response to their crying infant mothers may exhibit disoriented behaviors that may include wandering about in a spell like or dazed manner. Intrusiveness is observed and may include such behaviors as, "pulling the child by the wrist, mocking and teasing, or withholding a toy" (p. 51). Some mothers who withdraw may fail to greet the infant, avoid eye gaze and interaction. Mothers of infants with this attachment pattern may also incite abrupt state switches and fail to provide interactive repair.

Infants with disorganized attachment patterns present with disorganized and/or disoriented behaviors in the parent's presence. It is observed that infants may "freeze with a trance-like expression, hands in air; may rise at parent's entrance, then fall prone and huddled on the floor; or may cling while crying hard and leaning away with gaze averted" (Siegal, 2012, p. 99). This behavior is indicative of the child's effort to communicate with caregivers being met with repeated failure. Body action tendencies that develop with disorganized attachment patterns may include any of the following seven categories of behavior:

- 1.) Sequential contradictory behavior; for example, proximity seeking followed by freezing, withdrawal, or dazed behavior.
- 2.) Simultaneous contradictory behavior, such as avoidance combined with proximity seeking
- 3.) Incomplete, interrupted, or undirected behavior and expressions, such as distress accompanied by moving away from the attachment figure.
- 4.) Mistimed, stereotypical, or asymmetrical movements, and strange, anomalous behavior, such as stumbling when the mother is present and there is no clear reason to stumble.
- 5.) Movements and expressions indicative of freezing, stilling, and "under water" actions.
- 6.) Postures that indicate apprehension of the caregiver, such as fearful expressions or hunched shoulders.
- 7.) Behavior that indicates disorganization or disorientation, such as aimless wandering around, labile affect, or dazed, confused expressions. (Ogden, Minton & Pain, 2006 p. 52)

The infant with a disorganized form of attachment has been presented with an unsolvable problem

(Siegal, 2012). He is unable to achieve attachment for “when the parent is the source of fear and disorientation, it is impossible for the child to achieve an organized, effective adaptive state” (p. 104). When the infant’s defense systems and attachment systems are simultaneously or sequentially engaged the infant’s inability to achieve adaptive behavioral patterns damage physical, emotional and mental development. These infants become children with “attention difficulties, hyperactivity, eating difficulties, and often develop learning, mood, and conduct disorders” (Levine, 2007, p. 310). If untreated, children with disorganized attachment patterns are often diagnosed with personality disorders as adults (Fisher, 2014).

Attunement

Attunement can be thought of as “bringing into harmony” or a feeling of “being at one with another being” (Kossak, 2009, p. 15). The psychologist Richard Erskine (1998) defined attunement as “kinesthetic and emotional sensing of others – knowing their rhythm, affect and experience by metaphorically being in their skin, and going beyond empathy to create a two-person experience of unbroken feeling connectedness by providing a reciprocal affect and/or resonating response” (as cited by Kossak, 2009, p. 15). Kossak further explained attunement as, “as a felt embodied experience that can be individualistic as well as communal, that includes a psychological, emotional, and somatic state of consciousness.” Such states of attuned consciousness between people requires ‘mutual empathy’ supporting what Jordan (2009) called a ‘growth fostering relationship.’ A mother’s sensitivity to her infant’s signals are vital to engaging the baby in the mutuality of an attuned relationship. Further capacity to engage in relationships with mutual empathy rely on the quality of this first relationship. The therapeutic relationship offers the opportunity to foster ‘therapeutic attunement’ (Kossak, 2009) that may support the development of a corrective therapist-client attachment pattern.

The infant’s secure attachment requires that her internal world be perceived and understood by her

mother, and that she is responded to by her mother with timing and effectiveness (Siegal, 2012). Siegel explained attunement as “the alignment of states of mind in moments of engagement, during which affect is communicated, via facial expression, vocalizations, body gestures, and eye contact” (p. 94). Affect attunement he stated occurs when an individual has the experience of ‘feeling felt,’ when the “emotional expression of each member of a pair is contingent with that of the other” (p. 94).

Harvey (1995) discussed attunement as a rhythmic match between the parent and child. He highlighted the works of Meekums (1991) which include ‘molding’ and ‘interactive synchrony’ (p. 169). Molding refers to the ways in which the parent-child’s bodies shape to fit or not fit in relation to each other. That is, are their shapes complimentary or attuned to each other? Interactive synchrony involves the matched timing of gestures and postures. The therapist will observe if the parent and child share the same rhythmic movements. It has been shown that increased molding and interactive synchrony is associated with improved parent – child relationship. Without a match in their rhythm Harvey maintained, “the child’s capacity for empathy and ability to share feelings is compromised at the body level” (p. 170).

Kossak (2009) discussed ‘embodied empathy’ as a body awareness and a wisdom or knowing. ‘Embodied attunement’ is seen when the mother responds to and matches the movement and rhythm qualities of her infant or young child, and they are comfortable and at ease. Infant or young children will become thwarted by movement patterns that “clash” with their own. Levy (2005) points out that, “when parenting figures are unable to adapt their personal movement preferences to synchronize and/or harmonize with the child’s, the child may become hampered in his or her psychodynamic growth” (p. 129).

Developmental Trauma

Fisher (2014) maintains that disorganized patterns of attachment are most often associated with neglect. She stated that, without the support of a regulating mother the child is “alone in the midst of

ongoing, daily eruptions of his own powerful emotions” (p. 7). The result of early life without alignment, recognition, soothing, rocking, singing, and rhythmic attunement as a source of regulation and comfort, the baby, is denied the opportunity to develop a sense of mother/other or a sense of baby/self. Awareness of the self and other is established within attachment processes and therefore the development of empathy. Affect regulation, Fisher maintained, is the most important accomplishment of the first three years of life but does not organize in those with developmental trauma. The regulation of an infant’s affective state is the prerequisite for the child’s felt sense of and awareness of their very existence. The ‘self’ and the recognition of and the reality of the ‘other,’ simply fails to develop with these children.

Fisher (2014) described children with developmental trauma as ‘out of sync’ rhythmically. Sensory input is the child’s first language and the quality of touch, and the feeling of being held, rocking and swaying in rhythmic song and vocalities of the infant’s caregiver facilitate the infant’s brain development. Fisher reports that her experience treating developmental trauma with neurofeedback indicates that the brain receives input in a rhythmic fashion. The child with developmental trauma will likely have a disturbed sensory integration system, as evidenced by sensitivities to sensory input including touch, bright lights and loud noise. Deficiencies in motor coordination and spatial awareness are observed and learning disabilities may develop. Fisher maintained that without intervention empathy fails to develop and social cues often go unnoticed, which will impact the ability for these children to form functional relationships. She asserts that children who have experienced developmental trauma are often diagnosed with personality disorders as adults.

Memory Development and Trauma

The infant is born with an overabundance of neurons and few synaptic connections. The facilitation of synaptic connections occurs within attachment system processes. The early securely attached interpersonal relationship helps the immature brain use the mature functions of the parent’s brain

to organize its own process. During the critical period of infancy, developmental overpruning occurs in those infants who experience overwhelming and chronic stress. The developing neocortex and limbic system are underdeveloped due to the overproduction of and release of stress hormones and the death of critical neurons (Siegal, 2012, p. 113).

Implicit learning during the first year of life, Siegal (2012) stated, becomes “deeply encoded,” shaping the child’s “architecture of the self.” Memory processes support the synaptic connections and neural pathways that give structure to the developing brain. Implicit memory involves the nonverbal aspects of our experiences, as opposed to explicit memory, which Siegal explained is “the layer of memory that during recall is coupled with an internal sensation of remembering” (p. 56). Explicit memory includes autobiographical and semantic representations. It is verbally accessible and requires focal, conscious attention for encoding and retrieval. Implicit memory is not verbally accessible and does not require conscious focal attention to be encoded or retrieved. Implicit memory includes “perceptions, emotions, bodily sensations, and behavioral response patterns” (p. 54).

The implicit memory encoding of a child’s attachment patterns experienced in the first year of life lays the foundation for development of the second-year explicit encoding. Explicit memory becomes present at about the first year of life. Prior to that, the infant and young child learns through implicit or body memory solely and “by a child’s first birthday, these repeated patterns of implicit learning are deeply encoded in the brain” (Siegal, 2012, p. 54). Children develop their internal witness, that is, awareness of the self through memory encoding processes. As Siegal stated, “our internal sense of who we are is shaped both by what we can explicitly recall, and by the implicit recollections that create our mental models and internal subjective experience of images, sensations, emotions and behavioral responses” (p. 71).

Siegel (2012) pointed out that the infant who becomes securely attached has had the repeated

experience of nurturing, perceptive, sensitive, and predictable caregiving responses from her mother that has become encoded implicitly in her brain and body. The less fortunate infant who develops insecure, or worse, a disorganized, attachment pattern, has experiences that are inconsistent or frightening and which become encoded as implicit/body memory. Siegal described this process of developing the self, as the “heart of implicit memory,” and that which shapes “the growing child’s architecture of the self” (p. 55).

Ogden, Minton and Pain (2006) reported that traumatized clients often present with symptoms rather than with coherent verbal stories. Because traumatic memory consists largely of reactivated, nonverbal memories, “these memories are split off from conscious awareness and stored as sensory perceptions, obsessive thoughts, and behavioral reenactments.... inaccessible to verbal recall, they typically remain unintegrated and unaltered by the course of time” (p. 234). Schore (2019) stated that these, “relational traumatic experiences are stored in imagistic procedural memory of the visuospatial right hemisphere, the locus of unconscious implicit and autobiographical memory” (p. 48).

Regulation Theory

Regulation Theory, developed by Allan Schore, is “an interpersonal neurobiological model of the development, psychopathogenesis, and treatment of early forming emotional core of the subjective self (Schore, 2019, p. 56). It is, “commonly understood that the left brain is associated with logic, cause-effect reasoning, verbal processing, and linear thinking, while the right is associated with nonlinear, holistic (big-picture) thinking, intense emotion, body sense, social awareness, and nonverbal communication” (Wylie, 2004). The development of the right brain precedes the development of the left and is facilitated by and dependent upon the attachment relationship (Schore, 2019; Siegel, 2012).

Attachment processes facilitate the development of the right brain, which is responsible for the regulation of affect and stress for the rest of the life span (Schore, 2019). The attuned mother will provide “well-modulated socioaffective stimulation,” facilitating “the growth of connections between

cortical limbic, and subcortical limbic structures that neurobiologically mediate self-regulatory functions” (Schore, 1994, p. 33). Studies show that the organization of the right brain (which precedes the development of the left) and assembly of limbic-autonomic circuits occur in a very specific pattern (Schore, 2019). This pattern Schore reported is as follows:

At 2-3 months, the right basolateral amygdala, which densely connects with higher cortical areas, begins a critical period of growth, initiating the infant’s burgeoning intersubjective functions. From 3 to 9 months, the anterior cingulate- a corticolimbic structure associated with responsivity to social cues-comes online, giving the infant even greater capacities for intersubjectivity and for receiving nonverbal communications of a “good enough” caregiver interactive regulation. From 10-12 months of age, the regulatory center in the orbitofrontal cortex, the attachment executive control system, begins its developmental growth period, which spans until the end of the second year. With optimal relational experiences, the vertical axis that connects the right orbitofrontal cortex with subcortical areas is well developed, allowing the right orbitofrontal cortex to regulate (and be regulated by) the right amygdala. (p. 67)

Through visual-facial, auditory-prosodic, and tactile-gestural affective communications, the mother regulates the infants developing central and autonomic nervous systems Schore (2019). Schore identified ‘mutual gaze’ as critical to the development of the synaptic connections of the occipital cortex. Research data he stated, indicates that the “future capacity to process social information expressed in face-to-face communications.....is dependent on caregiver-infant eye contact and visual gazing.....how often and in what contexts the mother and infant spontaneously look (and not look) directly at each other is of key importance”(p. 35).

Auditory-prosodic communications include, ‘infant-directed speech’ or ‘motherese,’ which Schore (2019) reports is “essential to the development of the infant’s right temporal areas, and the burgeoning

ability of reading the emotional tone of voice of others” (p. 36). Motherese as opposed to adult-directed speech is a “vocal expression of emotion to infants, is higher in pitch, has a wider pitch range, and exhibits exaggerated pitch contours. In addition, it is shorter, slower, and separated by longer pauses” (p. 36).

Tactile-gestural communications within the mother-infant dyad include “left sided cradling,” which is stated to be more “direct and immediate.” Schore (2019) points out that the infant and mother create a system of “touch synchrony,” in which communication and regulation of emotion occurs. Schore maintained that touch is the first medium of communication and that affectionate touch is needed for healthy right hemisphere development. Fischer (2014) reported that “the development of the infant’s cerebellum depends mostly on security, consistency, and rhythmicity of his parent’s holding” (p. 22).

Infant health assessments that include observation of early attachment patterns and early intervention during critical periods of heightened brain plasticity is a critical need. Furthermore, such “assessments of infant mental health in the first and second year must be relational and need to utilize nonverbal, bodily based measures of early forming right brain intersubjective affectivity and not later forming left brain language-based measures” (Schore, 2019, p. 83).

DMT Observation and Intervention

Tortora (2010) highlighted the eight nonverbal communications of emotion as observed by those trained in nonverbal assessment. The therapist will pay attention to the *Quality of eye gaze* and notice if, how, and when eye contact is made, and how long the gaze is maintained. The therapist will note the qualities of the gaze, including its intensity, whether or not it is frozen or transfixed, and/or if it is wandering or avoidant. As for *Facial expressivity*, the therapist will assess the congruence of affect and overall behaviors. The overall “feeling tone” the facial expression presents to their partner is noted. The dyad’s *Use of space* and spatial pathways are observed, specifically how the partners approach each other

directly or indirectly, and how they position themselves in relation to each other. The *Quality and frequency of touch and/or physical contact* are also observed. This will include how often and for how long and qualities such as, “tension,” “strength” or “passive” weight are noted. *Body Shape* observation includes the way that their bodies are shaped in relation to each other. The therapist will note for example if they are straight and rigid, or if they mold their bodies to one another. *Tempo of nonverbal movement style* includes the overall rhythms and whether there is a sense of synchrony. *Vocal patterns* are noticed, as well as the compatibility of tone and tempo with the overall rhythms of the non-verbal exchange. Overall *nonverbal behavior and regulation* are observed, paying attention to how their nonverbal communication may support or not support co-regulation (Tortora, 2010).

Blau & Reicher (1995) described the nonverbal behaviors observed in the parent infant dyad to include observation of the infant and parent’s use of *personal space*. Is there a shared personal space or is there a distance maintained? The therapist will notice the direction of the dyad’s *gaze*. That is, do they gaze into each others’ eyes, maintain a shared focus or pay attention to different things? The observer will note the pair’s body attitude as relaxed and open or constricted and tense. Does *molding* between the two occur? Do they appear comfortable when in close physical contact and does the mother respond to her baby’s need to readjust his body? *Exploratory and (or) blocking behavior* is whether the mother facilitates or interferes with her child’s attempts to explore the environment. *Contact seeking/avoiding* patterns are noticed with a mother and infant who seek contact or avoid each other. *Rhythmic interaction* between the mother’s movements, breath, and voice is noted as clashing with or complimenting her baby’s. The *degree of match or mismatch of movement qualities* is observed in the intensity of their interactions. Does one move quickly while the other moves slowly?

It is within these early nonverbal communications of emotion between parent and infant that child’s movement repertoire and style, signature of their unique experience, is formed. Observation of

such communications inform the therapist's understanding of their client's intersubjective experience. Tortora (2010) maintained that "nonverbal observational skills ascertain how the infant and parent experience each other.... pertinent information about each mover's implicit understanding and intersubjective motivations" (p. 48). Such kinesthetic understanding further informs treatment interventions used by the Dance movement therapist.

Through the design of interactive activities which utilize music, dance, movement and play the dance movement therapist may create "spontaneous, affectively-matched, emotionally and socially interactive exchanges...which fuel the attachment process" (Tortora, 2010, p. 48). Dance movement therapy is uniquely suited for treating early disordered attachment, as "it is the bodily dimension that distinguishes dance therapy from other expressive therapies and from other forms of therapy" (Gross-Cohena & Zvi Eisikovits 2017 p. 59). As Pierce (2013) points out, dance movement therapy is unique in its ability to provide direct access to the right brain.

Blau & Reicher (1995) discussed their early intervention work with parents and their children and they explained that helping parents to modify the "level and intensity" in response to their child's nonverbal communications supported caregivers in matching the children's spontaneous behaviors. This matching insured the mutual attunement necessary for secure attachment. During dance movement therapy sessions these authors state that they help parents become aware of their infant's spontaneous communications and develop synchronous rhythmically attuned patterns.

While the therapist might feel inclined toward viewing the infant as the client, authors Blau & Reicher (1995) point out the importance of treating the relationship as key to reshaping attachment patterns. The therapist' sensitivity to, and support for the caregiver's experience is vital to establishing a trusting relationship in which the parents will not become resistant or defensive. They recommend that the therapist find a way of 'being with' the family that allows them to be natural in their exchange *and*

permits the therapist's offerings of support to help adjust maladaptive patterns.

Doonan & Brauninger (2015) observed that one of the challenges new mothers face in is making the adjustments to share her physical, social and emotional space with her new baby. Programs such as the Prenatal Project founded by Judith Kestenberg that trained prospective parents and obstetric nurses to become aware of the preferred movements of the fetus and newborn are reported to facilitate early mother-child attachment. Such programs that support attachment processes are not always available to those in need of services. People come into therapy at various stages of development with disordered attachment patterns that have become deeply encoded. Treatment interventions suited to the needs of clients at these later stages of development are required.

Treatment of attachment trauma that is accomplished within the therapeutic relationship may require that the client and therapist be willing to back in time together. Accessing the preverbal and unconscious memory of the client's infancy and early childhood is often done through the process of free association as introduced by Freud, (1930), which uses "spontaneous word play to free up unconscious energies," and Jung (1962), "used sand play and other free improvisational art forms that included dance and music to release unconscious materials and resistance" (Kossak, 2009, p. 15).

Dance Movement Therapists have been supporting clients in revealing their preverbal, unconscious and traumatic experiences intuitively in a multitude of ways since the 1940's (Levy, 2005). One such pathway includes the practice of authentic movement. Originated by Mary Starks Whitehouse whose pioneering work and development of the "witness" has since inspired Dance Movement Therapists to continue to integrate this practice into their own work.

Authentic movement is a form of improvisational movement practice that can be viewed as a "free flow of spontaneous energies toward achieving an experience of unitive consciousness to self and the world" (Kossak, p. 14). Lavendel (2017) discussed her Authentic Movement practice, "Together we listen

to what her body knows. In this archaeology of embodied experience, we unearth, from dark hidden recesses, experience that has never been conscious (often preverbal), or feelings which have been unwelcome, unbearable or unloved” (p. 214). The witness creates a space for the mover to close their eyes and move from the impulses that arise from sensations, emotions, intuition, images and memory. The therapist’s role as the witness is to create a safe environment in which the mover can bring unconscious material into consciousness. Tortora (2006) stated that the witness is not simply watching the mover but is engaged in “an active experience that may inspire images, sensations, feelings, ideas, personal memories and sensorial reactions” (p. 220) of their own. The witness carefully tracks their experience and the mover and witness then participate in dialogue. Lavendel (2017) maintained that “the nonverbal must be brought into consciousness and language in order to be integrated within the totality of one’s being” (p. 215).

Tortora (2010) pointed out that the primary focus of Dance movement therapy with children is emotional expression, building relationships, and improving social skills. Nonverbal means of communication support the unfolding of the child’s historical social and emotional experience thereby revealing preverbal, unconscious, and traumatic experiences. Psychotherapy distinguishes dance/movement therapy from other body-based therapies however the growth and integration of motoric, perceptual-motor, verbal processing, and social skills, cognition, and communication are also evident. (recall the discussion of developmental issues that arise with children who have developmental trauma)

The mother is the baby’s first witness: “It is the experience of being seen, or not seen, in our earliest relationships that greatly contribute to our sense of being understood and cherished.” As we know, the experience of children with developmental trauma is of having no witness, of not being seen (Tortora, 2006, p. 221). Both Whitehouse and Adler related the adult mover-witness relationship to the experience of an “infant’s earliest explorations and discoveries within the primary relationships” (p. 222). Being

‘seen’ extensively by an external witness supports inner witness development which supports the individual’s ability to witness another.

The traditional practice of Authentic Movement is not suitable for work with children who lack the conscious awareness of actions, the ability to move with their eyes closed for any length of time, or with the ability to reflect on their experience. Adaptations to the discipline were made by Janet Adler, whose pioneering work with Autistic children has greatly influenced DMT’s work with children today. One such adaptation includes the role of the ‘embodied witness’ one who Tortora (2006) states, “moves with the mover” (p. 225). Adler (2003) stated that “during these moments of relationship, the child was able to experience the early beginnings of the development of an inner witness in which one comes to know and develop one’s own true sense of self” (as cited by Tortora, 2006, p. 225).

The development of the child’s inner witness is largely dependent upon the therapist’s ability to enter into movement dialogue with the child from a place of not knowing. Tortora states that, “improvisational spontaneity is the element that encourages a relationship to grow, thereby creating a reliable and trusting attachment.... It requires the therapist to see the child as the teacher, in a place in which they both enter the unknown space together in relationship, watching, listening, and feeling. It asks the therapist to trust that through this process the appropriate course of intervention will unfold.... The goals of intervention are continually revised as she listens to both personal reactions and to the child’s responses.” In alignment with Tortora, Allan Schore (2019) wrote:

Beneath the exchanges of language, implicit affects of the patient are communicated to and regulated by implicit systems of the therapist. From the first point of intersubjective contact, the psychobiological-attuned intuitive clinician tracks the nonverbal moment-to-moment rhythmic structures of the patient’s internal states and is flexibly and fluidly modifying his or her own behavior to synchronize with that structure, thereby co-creating with the client a growth

facilitating context for the organization of the therapeutic alliance. The attachment between therapist and client is established over time, allowing for the expression of unconscious socioemotional experience that resonate with the original infant-mother (and later toddler-father) attachment history. (p. 30)

The skilled therapist will join in relationship with their client from this place of not knowing. Through this process the therapist will achieve an awareness of their intersubjective mind. This achievement Schore stated is accomplished “not through controlled voluntary action but by ‘letting go’ of control” (Schore, 2019, p. 67). That while we support the use of regression on the part of the client it is the therapist’s willingness to mutually engage with their client in this state of regression that supports the working through of trauma. Winnicott (1958) clearly stated his view regarding regression, he pointed out that while the therapist may feel that there is some danger in the regression of a client, “the danger does not lie in the regression but in the analyst’s unreadiness to meet the regression and the dependence which belongs to it”(as cited by Schore, 2019, p. 57). The therapist who is skilled in managing regressive states will likely lead the therapeutic pair to more quick acceptance of the regression and meet it fully. Therefore it becomes “less likely...that the patient will need to enter into an illness with regressive qualities” (p. 57).

Mobilization in treatment occurs by the “promotion and utilization of regression, and that the clinician must validate the patient’s regressive experience so that the patient is not left alone with it” (Schore, 2019, p. 77). Levine (2010) points out the dangers of leaving a traumatized client while in a state of regression:

When therapists perceive that they must protect themselves from their client’s sensations and emotion, they unconsciously block those clients from therapeutically experiencing them. By distancing ourselves from their anguish, we distance ourselves from them and from the fears they are struggling with. To take a self-protective stance is to abandon our

clients precipitately. At the same time, we also greatly increase the likelihood of their exposure to secondary or vicarious traumatization and burnout. (Levine, 2010, p. 41, cited by Schore, 2019 p. 78)

Mutual regression includes the therapist being willing to “actually transport oneself with the patient into that period of the past” (Ferenczi, as cited by Schore, 2019, p. 73). In this mutual state of regression exists the opportunity for reworking the old implicit, procedural memories that are no longer serving the individual as well as to create new more integrated explicit narratives. The therapist’s development of skills as a witness supports them in navigating what Schore (2019) termed right-brain to right brain communication. Lavendel (2017) highlights the important role of the developed witness in such interaction between client and therapist: “The study of the role of witness has deeply informed all relationships in my life and has been the most profound and helpful guide in my work as a psychotherapist” (p. 212).

Having been extensively ‘seen’ by a witness herself the dance movement therapist is then prepared to witness another (Tortora, 2010). Lavendel (2017) pointed out the importance of the witness’ depth of self-awareness and healing, “the witness has moved through the density of her own psychological history, meeting herself in every shadowy corner, thereby enabling a clearing, a release, an opening into clearer presence, able to be with the mover without so many of the projections that obscure clear seeing” (p. 212). The witness having been extensively witnessed by another is able to bring a “full-bodied presence, deeply concentrating on her own experience while closely accompanying the mover. Every cell of the witness is awake to feel how her own being resonates as she sees the other” (p. 212).

Ogden, Minton, and Pain, (2006) discussed patterns observed in adulthood as implications of their early attachment patterns. Therapists willingness to engage in relationship that alters attachment patterns may require walking into the shadows of their clients’ past as well as their own. Training of clinicians that

include the development of an embodied witness prepare the therapist to addressing early attachment patterns often include regression and the client's need for mutuality in that state. witnessing requires the therapist to have a certain degree of fearlessness to and willingness to step into the unknown without crumbling or running away. The question is as Schore asked can you both "hold in the right" (p. 78) - even when it feels, "as if the ground is threatening to slip away" (Reik as cited by Schore, 2019, p.56).

Not only do we grow through relationship and seek deeper connections but, "growth fostering relationship later in life can to some extent rework old destructive neural patterns" (Jordan, 2009, p. 76). The extent to which we can rewire neural pathways is gaining greater attention. With the understanding that "neurons that fire together wire together," (Siegal, 2012, p. 49) and that the malleability and heightened plasticity of the infants brain far exceeds the adult brain, it is curious how much can one alter one's neurological makeup at different stages in development, or how fast and to what degree. Movement therapists see individuals "transformed before their eyes, using their bodies to move through pain and gain insight into their deepest levels of unconscious processing" (Winters, 2008 p. 123). This type of witnessing provides, and results in, feeling connected, attuned, and cared for by another.

Discussion

Exploring the neurological impacts of all psychotherapeutic interventions utilized in the treatment of trauma demonstrates the plasticity of the human brain and its ability to create new neural pathways. Further research into the neurological rewiring that occurs in growth fostering relationships, specifically, within the dance movement therapy relationship will demonstrate the power of the authentic movement relationship in the critical treatment of attachment related trauma.

The neurobiological processes that are powered by attachment processes begs for better assessment of infant mental health. Clinicians with well-developed observation skills of the nonverbal intersubjective experiences within the mother-infant relationship would open the doors to these better

assessments and early interventions which support attachment processes and the prevention of developmental trauma. Health care that includes programs designed to facilitate embodied attunement and securely attached relationships which target risk populations will serve society at large very well. For children and families in crisis's associated with intergenerational trauma, treatment is critical.

There appears to be a growing trend in research and writings by trauma specialists in moving away from traditional talk therapy and toward a more embodied, intersubjective and relational therapeutic experience. The importance of attunement, of feeling connected to others, 'feeling felt,' or having the experience of being 'witnessed' must never be overlooked, as it is vital to a person's health and a powerful treatment of psychopathology. We know that a secure attachment is an individual's greatest defense against psychopathology, we as health care professionals must give it greater attention.

This writer proposes the inclusion of experienced clinicians who are infant mental health specialists trained in nonverbal assessment of the primary caregiving relationship be included in overall health and wellness checkups. Further research would include the assessment of the infants' mental health at each critical period of the first year as outlined by Schore above. Utilizing an assessment of the nonverbal qualities in the early attachment relationship as discussed above by Tortora, Blau & Reicher, would deepen the understanding of the intersubjective experience of the dyad and quality of attachment, and make early intervention more available for families struggling with disordered attachment.

Further research conducted within the framework proposed would include a study of infant mental health which would be composed of two groups including the experiment group in which early assessment and dance movement therapy interventions are implemented and the control group, which would participate in the assessment process only without the dance movement therapist's intervention. Tracking neurological development of the two study groups throughout infants' first year this writer proposes would indicate that the dance movement therapist's interventions will lead to an increased

finding of secure attachment patterns in the experimental group than the findings of the control group.

The expectation is that increase in securely attached infants of the experiment group will show an overall healthier neurobiopsychological development. Longitude studies tracking the child's development across the life span would offer further insight into the long-term impacts of early assessment and intervention of attachment in the experimental group as compared with the control group. How often secure attachment occurs naturally among the subjects in the control group would contribute to literatures concerned with the percentage of children who develop secure, insecure, or disorganized attachments.

Intergenerational transmission of traumatic attachment that leave children critically wounded requires a deep understanding of their experience in relationship to support the healing process. Establishing secure attachment patterns within the therapeutic relationship has been shown to create more attuned, empathic relationships for the individual in therapy and in their personal relationships. A decrease in cognitive, physical and mental health issues is associated with development of secure attachment across the lifespan. Dance movement therapy has been shown a powerful modality in treating attachment related trauma. Greater attention to this field of study and practice would offer clinicians further insight into the experiences of their client's and deepen their understanding of the client, the self, and the therapeutic relationship.

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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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