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The Weight of Trauma: Exploring a New Method in Dance/Movement Therapy for Trauma

Processing with Adolescents

Capstone Thesis

Lesley University

May 5, 2021

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Dance/Movement Therapy

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Abstract

This author developed a movement-based trauma informed method that implemented symbolic play with sandbag weights with light and dark colored scarves, with adolescents at the Boys and Girls Club of Fitchburg and Leominster, MA. This thesis was developed to observe how adolescents prioritize the magnitude of their trauma experiences to serve as additional insight towards treatment planning. Over a four-week process, participants created artistic responses to the trauma they identified most prevalent and engaged in symbolic play with different mediums in order to ultimately choose which prop felt most representative to how they viewed their trauma. This movement-based study supports the needs to expand the props used in the field of dance/movement therapy as well as provide a new form of therapeutic assessment for treatment planning that actively encourages the autonomy of adolescents without violating any ethical codes.

Introduction

Current research suggests that preexisting psychotherapeutic practices of trauma exposure have been predominantly explored among adults rather than adolescents (Grasser et al., 2019). This discovery led me to further investigate the ways in which trauma work is done with adolescents – specifically expressive movement in trauma informed work. This thesis will explore how adolescents' view and assess the magnitude of their trauma through dance/movement therapy (DMT) and the concept of symbolic play. This thesis will also explore the need to expand DMT props that challenge the efficacy of “light” and “bright colored” materials that are predominantly used in the field.

This study was conducted with adolescent individuals aged 8-11 at the Boys and Girls Club of Fitchburg and Leominster (BGCFL), located in Leominster, Massachusetts. An adolescent individual falls between the age ranges of 10- 19 years old. The adolescent population is a group more likely to be subjected to multiple physical and social changes that not only effect executive functioning but overall morale and autonomy especially in adulthood (Csikszentmihalyi, 2021). This includes (but not limited to) hormonal imbalances, changes in social groups, different education settings, puberty and course of neuromaturation (Csikszentmihalyi, 2021) which all holds significance to the relationship of the mind and body connection. This also brings into question if current practices within trauma work can be further expanded in application with adolescents, considering many findings surrounding major trauma and stress related disorders are based on adults (APA, 2008). Because of the multifaceted nature of adolescent development, I felt great desire to implement DMT work with this population, that would address these needs with adequate symbolic representation in relation to trauma experiences.

The American Dance Therapy Association defines DMT as “the psychotherapeutic use of movement and dance to support intellectual, emotional, and motor functions of the body. As a modality of the creative arts therapies, DMT looks at the correlation between movement and emotion” (ADTA, 2020). Dance/movement therapists not only engage in psychotherapeutic movement interventions, but also conduct and produce clinical documentation, research, assessments and promote healing through movement (ADTA, 2020). These aspects of healing can include improved self-esteem, body image, body awareness, self-efficacy, communication and coping skills.

One common framework used in the field of DMT is symbolic play. Symbolic play explores participant’s ability to associate or dissociate a symbol or prop from what it symbolizes in reality such as turning a bowl to a steering wheel of a car (Bretherton, 1984). This thesis will aim to provide a creative outlet for clients to express how they view different aspects of their lives. In relation to the field of DMT, symbolic play serves as a nonverbal method that aides in defining and redefining one’s identity (including identity in relation to others) through art, which contribute to the process of healing (Serlin, 2020). Rodgers & Furcon (2016) emphasizes the importance of DMT early intervention practices with youth, especially in community settings to decrease development of risky behavior in adulthood. This thesis will expand on how adolescents in particular use symbolic play to define the magnitude of their life experiences all while exploring the efficacy of the ones that have been commonly used in DMT.

Throughout my time in Lesley’s Expressive Therapies program, I have participated in a variety of course experientials, internships and ADTA conferences where I noticed a predominant theme of light and bright materials (such as pastel scarves and neon colored octabands) in what are considered to be trauma informed spaces. This made me question the lack

of heavy or dark objects offered. Trauma does not strike me as being light or bright so why do most of DMT intervention props reflect as if it is such?

In addition to a lack of range in DMT intervention props, I questioned the general cultural assumptions of adolescents' being naive or vulnerable. This led me to reflect on the popular proverb "children should be seen and not heard" and how that developmentally affects a child's authentic expression around others. Tate, K., & Meeuwesen, L. (2001) support this idea by addressing the gap in communication between minors and clinicians which dismisses the opportunity for adolescents to advocate for how they see and wish to have their needs met. Similarly, in many programs children under the age of 18 are often not fully involved in the initial intake and consent process of any type of treatment. As a result, a possible gap in communication could form between clinician and client, for example when the adolescent views another trauma or injury as high priority that differs from the perception of the parent/guardian. Considering the ethical process of completing clinical intakes for minor adolescents, this thesis will provide insight to a new way of giving voice to adolescents by having them assess their priority of needs with physical representation in the therapeutic space.

With this thesis I am proposing a new intervention of incorporating sandbag weights along with dark colored scarves in the use of symbolic play to provide not only physical representation but to enhance client-therapist communication by including the input from adolescents' self-assessment of the magnitude of their lived trauma without violating any ethical codes. This thesis will consist of a literature review analyzing multiple areas of defining trauma at large and with adolescents, communication gaps within treatment, the use of symbolic play, DMT and non DMT treatment for this population and the benefits of introducing sandbag weights. This thesis will also consist of the methodology structure, results of how participants

prioritized their trauma experiences and discussion section for further implications of expressive trauma informed work with adolescents who have experienced or been exposed to trauma.

Literature Review

In order to explore trauma informed work, it is important to not only understand how it is defined, but its effects and the current practices, including what is missing in the work. The idea of trauma is not new but there may be a call as to how it can be reformed to more accurately support the needs of adolescents, considering the lack of research. This literature section of the thesis will review how trauma is defined today according to the Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*), its effects on adolescents exposed to trauma, communication gap in adolescents' experience of trauma and treatment planning, symbolic play, benefits of dance/movement therapy (DMT) and dance/movement therapy with adolescent exposed to trauma, and weights as an intervention prop.

Defining Trauma

According to the *DSM-5* Trauma can be defined as the “psychological distress following exposure to a traumatic or stressful event” (*DSM-5*). Trauma can result from a significant event (or multiple) or set of circumstances sustained as “physically or emotionally harmful or life threatening”, that could have perennial impact on an individual (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2019). Examples can include witnessing/experiencing significant death in an individual's community, physical violent attack, interpersonal violence, neglect, sexual abuse or extreme changes in living environment. The three categories of defining trauma are acute trauma (experiencing one single stressful or traumatic event), chronic trauma (repeated or prolonged exposure to traumatic or

stressful event) and complex trauma (exposure to multiple traumatic events). Being subjected to such experiences can interfere with not only daily life functioning but mental, physical, social-emotional and spiritual well-being (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2019). With such impacts to an individual - development of traumatic and stress related disorders due to that traumatic experience can occur. These primary diagnoses include reactive attachment disorder, disinhibited social engagement disorder, post-traumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders (*DSM-5*). Reactive attachment disorder is a diagnosis prominent in children that experience emotional withdrawal from parent/care giver following exposure to traumatic event (*DSM-5*). This includes unresponsiveness to comfort nor seeking comfort when in distress (*DSM-5*). Symptoms include lack of emotional or social response opposite of positive affect and uncontrolled feelings of sadness and irritability (*DSM-5*). These symptoms must be present for more than 1 year and before the age of five with a developmental age of at least nine months in order to qualify (*DSM-5*). To qualify as “severe”, all symptoms must occur at levels of high intensity (*DSM-5*). However, it is important to note differential diagnosis in individuals who experience living on the autism spectrum, with intellectual disabilities, or depressive disorders in order to avoid confusion and possible misdiagnosis (*DSM-5*). Important comorbidities to note with reactive attachment disorder include cases of neglect, cognitive delays, language delays, and stereotyping (*DSM-5*). Severe malnutrition and depressive symptoms can also take place with individuals diagnosed with reactive attachment disorder (*DSM-5*). Disinhibited social engagement disorder involves the lack of hesitance from a child when engaging with unfamiliar strange adults without consulting a familiar one (*DSM-5*). This includes readily forming trust from the atypical child behavior (like shyness, hesitation or reserved trust) when meeting new

adults and lack of social-cultural norms or boundaries (*DSM-5*). For an individual to qualify under this diagnosis, developmental age must be at least 9 months (*DSM-5*). To note if disinhibited social engagement disorder is persistent or not, these behaviors must have a duration of at least 1 year or if it occurs at high intensity, it is to be noted as “severe” (*DSM-5*).

Differential diagnosis consists of autism spectrum disorder; Attention Deficit Hyperactivity Disorder (ADHD, which can also be a concurrent diagnosis); and intellectual disabilities (*DSM-5*). There is still a need to expand comorbidities with this diagnosis due to lack of research, however it is important to consider conditions and stereotypes such as cognitive and speech delays, intellectual disabilities and history of neglect. Post-traumatic stress disorder (PTSD) is the experience of repeatedly reliving (consciously or subconsciously) a severe traumatic event post initial exposure (*DSM-5*). These traumatic events can include witnessing or being exposed to acts of violence, severe injuries, a significant death, abuse, sexual assault, natural disasters or engaging in high stress work environments that force constant exposure to stressor such as historical cultural violence, combat, first responders and other essential workers (*DSM-5*). Symptoms of PTSD may vary in its psychological and somatic presentations. Some examples could include nightmares, negative affect, avoidance, hypervigilance, hyperarousal, intrusive thoughts, spontaneous flashbacks, or fight/flight responses like freezing, running, screaming, or uncontrolled urination (especially common in children) (*DSM-5*). In order for an individual to qualify under having PTSD, symptoms following exposure to trauma must be present for at least a month. With specifying this diagnosis, it is important to observe if delayed expressions are present after six months or more post event, and dissociative symptoms such as depersonalization (state of being detached from body and feelings like in dream-like state) or derealization (where environment and surroundings seem distorted in similar dreamlike state)

(*DSM-5*). Differential diagnosis include substance use related disorders, physical disorders (like stroke or other traumatic brain injuries), mood and anxiety disorders, and reactions to stressful events that lie within common/typical human response (*DSM-5*). According to the *DSM-5*, “individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (i.e., depressive, bipolar, anxiety, or substance use disorders)” (*DSM-5*). However, when it relates to young children and adolescent’s PTSD comorbidities differ from that of adults with oppositional defiant disorder and separation anxiety disorder being predominant comorbidities (*DSM-5*). Acute distress disorder like PTSD includes similar symptoms previously described of intense recalls following a traumatic event; however, the difference is that with acute distress disorders, symptoms occur immediately after event lasting for a month or less rather than PTSD 1 month post event symptoms (*DSM-5*). Typical duration for this diagnosis is 3 days to a month post exposure (*DSM-5*). Differential diagnosis of acute distress disorder includes substance use, traumatic brain injuries, psychosis, adjustment disorders (including mood disorders), panic disorders, dissociative disorders, obsessive-compulsive disorder (OCD) and PTSD (*DSM-5*). Adjustment disorder is the development of amplified emotional or behavioral symptoms following exposure to traumatic or high stressor which occur within 3 months of exposure but no longer than 6 months (*DSM-5*). Symptoms include depressed mood, anxiety, mixed anxiety and depressed mood, disturbed/inappropriate behavior, mixed disturbances of emotions and behavior, and other unspecified maladaptive reactions such as social withdrawals or lack of motivation to be productive (*DSM-5*). Specifiers with adjustment disorder include acute (lasting less than 6 months) or chronic (symptoms persisting for at least 6 months but onset not lasting more than 6 months after the stressor ended) (*DSM-5*). Differential diagnosis includes major depressive

disorder, PTSD, personality disorder, other psychologic impacts that may affect other medical conditions, and typical normal stress reactions (*DSM-5*). Most mental disorders can be a comorbidity with adjustment disorders as well as any medical disorder (*DSM-5*).

One very relevant diagnosis in relation to cultural trauma that is not present in the *DSM-5* is post traumatic slave syndrome (PTSS). Dr Joy Degruy theory of PTSS (originally developed in 2005) is the continuously shared multigenerational trauma among Black and African American people stemming from the capture of Africans for slavery enduring psychological, emotional, and physical abuse (Degruy, 2017). Since the Transatlantic Slave Trade, the U.S has continued to devalue Black lives or BIPOC (Black Indigenous People of Color), in multiple oppressive forms. These effects are still a part of recent and current history of cultural oppression including (but limited to) Jim Crow, Civil Rights Movement, Mass incarceration, and Black Lives Matter movement in protest of the excessive force and brutality at the hands of police officers. According to the American Psychology Association, Black/African Americans and people of color face high risk for physiological and psychological effects due to the stress of racism and discrimination which could lead to severe chronic health conditions Certain measures (APA, 2013). Because of this BIPOC may result in deploying “protective factors to defend themselves from the horrors of their realities” (Campbell, 2018, p. 8-9). This is relevant cultural considerations when working with adolescent of color because these historical impacts affect how Black and African American adolescents see themselves as valued members of society that differs from clients who are not BIPOC. Historically this population has faced a multitude of discrimination, and oppression such as red lining, racial slurs and police brutality including the re-traumatization of recordings released throughout multiple televised and social media platforms. With the conversation of trauma and its social-cultural complexities, it is important to

take note and expand further research of cultural impacts and comorbidities for all diagnosis including other specified or unspecified diagnosis as it related to trauma. This thesis will explore the relation of these impacts on adolescent individuals who have personal experiences with trauma.

Adolescents Exposed to Trauma

Post traumatic responses may share similarities but are not always translatable cross populations, especially as it relates to adolescents. Adolescents who experience traumas, including complex traumas, can have responses that differ from adult responses (NCTSN, 2008). If untreated, these behaviors learned during this pivotal time of development could have long lasting life impacts affecting adulthood. Exposure to trauma can affect at least one of the following areas of development: attachment styles, biology/neurobiology, cognition, affect/emotional regulation, behavior impulse, dissociations, and self-awareness (or concept of self) (Green & Myrick, 2014). The National Child Traumatic Stress Network (NCTSN) supports this idea, claiming trauma exposure can affect a child and adolescent's physical and mental health, behavioral changes, lack of self-regulation, self-awareness, optimism, difficulties forming relationships/attachment styles, lack of interest in previous hobbies/interest, academic difficulties, difficulties with attention, disturbed eating and sleeping habits, and long term health (stemming from risky behaviors such as drinking and smoking). Regarding adolescents' affect, post traumatic responses may vary to overly sensitive to complete void of emotions withholding them or reflecting the behavior adults around them portray/think they should portray (NCTSN, 2008). In addition, adolescents may also experience high detachment to their lived experience of post trauma seeking to disconnect from self and their environment potentially creating walls between themselves and others around them (Blaustein & Kinniburgh, 2018).

Adolescents exposed to trauma are more susceptible to heightened levels of stress than adolescents who have not experienced severe trauma (Finkelhor, Omrod, & Turner, 2007). Research shows that adolescents who are exposed to multiple traumas are more likely to experience “social isolation, difficulties with empathy, unexplained physical symptoms/increased medical issues, increased difficulties regulating and expressing emotions, poor impulse control, self-destructive behavior, aggression sleep disturbances, difficulties with body image, low self-esteem, shame, and guilt” (NCTSN, 2008). Research also suggests that adolescents exposed to more than one trauma are more likely to be subjected again to another form of victimization forming “polyvictimization” (Finkelhor, Ormrod, & Turner, 2007). It is not uncommon for traumatized youth to display initial mistrust in the therapeutic process. However, if not addressed appropriately, the further into adulthood adolescents grow these behaviors and symptoms can become unproductive to achieving healthy development and overall well-being (NCTSN, 2008).

Treatment for Adolescents with Trauma

The current popular non DMT treatment for adolescent trauma is cognitive behavioral therapy (CBT) however this approach is heavily based on the results of adult studies (APA, 2017). CBT has had a long-standing reputable reputation with individuals/groups who experience psychosis and have been exposed to trauma (APA, 2017). CBT application and approach centers around implementing manageable coping skills through redirecting behavioral patterns, problem-solving, increasing self-esteem, and providing insight to apply towards reality vs “distortions” in order to decrease psychological suffering (APA, 2017). The arts can be used as a tool to emphasize self-exploration and healing in a creative way all while incorporating psychotherapeutic approaches (i.e. problem solving, self-regulation, insight etc.). Specifically in expressive arts therapies, mindful practices meet emotional sensory processing through the

creative modalities of music, art, dance/movement, poetry, or drama which can coincide with the same missions of CBT. This partnership is understood to be an extension of how one can still obtain the goal of process and healing in CBT yet form an additional creative outlet to aid in that journey with a multitude of sensory mediums. In this case, a need of expansion in mediums with introducing dark and heavy materials to offer a more accurate representation within the psychotherapeutic journey.

Communication Gap in Adolescent Treatment Planning

In addition to lack of range in DMT intervention props, I wish to question the general cultural assumptions of adolescents being naive or vulnerable. Adolescent years are a time of many physical, developmental and hormonal changes that can make them vulnerable, however that shouldn't make their view and opinions less valuable especially when it comes to their care. Adolescents are often portrayed as immature, unstable emotionally or inferior to adults (references). This led me to reflect on the popular proverb "children should be seen and not heard" and how that developmentally affects a child's authentic expression around others. Tates and Meeuwesen (2001) support this idea by addressing the gap in communication between minors and clinicians which dismisses the opportunity for adolescents to advocate for how they see and wish to have their needs met. Studies show that minor clients have more insight to their health or illness than what is assumed by adult care giver (Tates & Meeuwesen, 2001). This highlights how children under the age of 18 are often not fully involved in the initial intake and consent process of any type of treatment. As a result, a possible gap in communication could form between clinician and client, for example when the adolescent views another trauma or injury as high priority that differs from perception of the parent/guardian. Research also suggests that clinicians may be overestimating the trust between client-therapist alliance with adolescents

and should implicate a structure to avoid preconceived biases that may be felt by the adolescent client and center around making sure adolescents felt seen and heard (Hart & Chesson, 1998).

Hart and Chesson (1998) stress that “Children are major users of health services but are rarely consulted as healthcare consumers” (Hart & Chesson, 1988, p. 1600), which contribute to the schemas of health care workers such as doctors, hospital staff and other health care workers are not acting in their best interest rather than their caregivers (Hart & Chesson, 1998). Because of this, adolescents should be brought into the conversation regarding their care to strengthen client-clinician relationship in order to reach satisfactory care, comply with treatment planning moving forward and overall better health outcome (Ellis, 2001). This is especially important for clinicians to consider in assessment as this could affect client prognosis. When considering the evidence of communication gaps, youth as consumers should be at the forefront of this process however it should be done in a manner that clinicians find a balance of information gathering without violating ethical standards. The ADTA code of ethics state: “Minor clients.

Dance/movement therapists inform minor clients of the limits of confidentiality with regard to parent and guardian legal rights to information. Dance/movement therapists inform parents and guardians of their legal rights to information consistent with age of minor and legal and custodial arrangements. However, therapists also discuss with parents and guardians the benefits of maintaining therapist-client confidentiality” (ADTA, 2015, p. 4). Similarly to the ADTA, the American Counseling Association ACA code of ethics section A.2.d., under “Inability to Give Consent” says that,

when counseling minors, incapacitated adults, or other persons unable to give voluntary consent, counselors seek the assent of clients to services and include them in decision making as appropriate. Counselors recognize the need to balance the ethical

rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf” (ACA, 2014, p. 4).

The American Mental Health Counseling Association (AMHCA) also supports this stance stating,

“when a client is unable to provide consent, CMHCs act in the client's best interest. Parents and legal guardians are informed about the confidential nature of the counseling relationship. CMHCs embrace the diversity of family systems and the inherent rights and responsibilities parents/guardians have for the welfare of their children” (AMHCA, 2020, p. 4).

Research suggests that adolescents may be more expressive of their thoughts and values if pursued using appropriate art-based methods (multiple references). Using expressive art as a means for information gathering to better align with the needs of a minor client can present “safer, easier, less threatening and less confusing method” for children while also being more enjoyable for them” (Hart & Chesson, 1998, p. 1602). Considering the ethical process for completing clinical intakes for minors, this thesis will provide insight to a new way of giving voice to adolescents by having them assess their priority of needs with symbolic representation in the therapeutic space in addition to treatment planning.

DMT

“Dance/movement therapists focus on helping their clients improve self-esteem and body image, develop effective communication skills and relationships, expand their movement vocabulary, gain insight into patterns of behavior, as well as create new options for coping with

problems. Movement is the primary medium dance/movement therapists' use for observation, assessment, research, therapeutic interaction and interventions. Dance/movement therapists help develop treatment plans and goals, document their work in clinical records and collaborate with professionals from other disciplines" (ADTA, 2020).

DMT & Symbolic Play

Symbolic play in DMT can serve as an effective and popular framework across a variety of populations. This framework combines the principles of symbolism and play. Symbolic play serves as a nonverbal method that aids in defining and redefining one's identity (including identity in relation to others) through art, which contribute to the process of healing (Serlin, 2020). Symbolic play explores participant's ability to associate or dissociate a symbol or tool from what it symbolizes in reality such as turning a bowl to a steering wheel of a car (Bretherton, 1984). Popularly recognized in the field of DMT for the implication of symbolism is Marian Chace who was the first professionally known full -time dance/movement therapist in the U.S (1947) and first president of the ADTA (1966-1968) (ADTA, 2020). Chace believed the use of symbolism in dance and movement could aid in problem solving and conflict resolution (Levy, 1988). Chace believed that the use of symbolism in dance and movement could aid in problem solving and conflict resolution (Levy, 1988). In addition to this, symbolic play supports the idea of empowerment through movement by allowing "repressed" or "frightening" emotions to take various forms (such as an image or symbol from a fantasy, in nature, or any part of an individual's lived experience/culture) in the therapeutic space to aid in the healing process (Levy, 1988). Symbolism in DMT allows an individual to explore the connection between internal and external experiences with movement and metaphors, and to create a form of overall communication that provides insight to patterns of "behavior, beliefs, relationships and

emotional state” (Ellis, 2001, p. 1). While symbolism is a significant part of this framework, we cannot forget the aspect of “play”. Play in psychology defined by Piaget is “the use of symbols to represent words, images, and ideas” in order to engage in the realm of imagination, especially to benefit child development (Lally & Valentine-French, 2019). As a result of Piaget observing difficulties with children processing complex situations, motives, and emotions with lack of abstract thinking, the idea of play in the therapeutic space was conceived (Kool & Lawver, 2010). Play in therapy bridges the concepts of fantasy and reality that can help process different schemas and regulate emotions meeting the age-appropriate needs of the child or adolescent (Kool & Lawver, 2010). Popularly known for the implication of humor and play in DMT is Trudi Schoop. Schoop successfully intertwined humorous play with her client’s experiences to make room for processing conflict and emotion in the therapeutic space (Levy, 1988). Her methodology consisted of improvisation and fantasy connecting individuals to diverse sides of themselves with different intensities to gain a deeper understanding of what it is they process not only in their mind and body; but the mind-body connection in relation to other living things in their environments (Levy, 1988). In regard to children and adolescents, play in therapy allows “the child or adolescent with a developmentally appropriate means of improving affect regulation, self-efficacy, problem solving, and formation of trust within the therapeutic relationship” (Green & Myrick, 2014, p. 138). Additional benefits consist of a better connection with the surrounding environment, strengthens the consciousness and emotional connection, serves as an additional representation of externalized emotions and also aids in relaxation or mindful recuperation (Davis, 1992). From this foundation of symbolism and play (symbolic play), nowadays, DMT hold the space to allow “witnessing, containing, mirroring, envisioning and provoking” roles that facilitate reflection and working through lived experiences (McCarthy,

2018) such as trauma. When individuals engage in symbolic play in DMT, acceptance and empathy can occur deeply at the unconscious level and introduce symbolic forms of communication from the individual to “experience a sense of deep trust and acceptance” (Levy, 1988, p. 37) of their own expressive process. This supports and encourage more movement and exploration within the therapeutic space (Levy, 1988) which is imperative to have when working with adolescents. In the field today, DMT have implicated and supported the concept of symbolic play throughout many work settings while also accompanying symbolic play with props such as the popular octaband, buddy bands, body socks, scarves or parachutes. However, the range in these commonly used materials in the field are limited to being lightweight or bright vibrant colors. Symbolic art can hold the power to represent a wide range of indescribable trauma and measure resiliency or safety (Serlin, 2020). In my inquiry I wish to argue: So why don’t our props reflect the diverse complexities that is trauma?

Benefits of DMT with Adolescents

DMT with adolescents can provide a multitude of benefits outside of the physical health aspect of movement, dance and play. By engaging in DMT practices, individuals can obtain “emotional, social, cognitive, and physical” improvements towards their health and overall well-being (ADTA, 2020). When working with adolescents these benefits can include self-regulation, social emotional and behavioral support, body awareness, fine motor skills and sensory processing, mindful practices, healthy coping techniques, promotion of healing and self-expression through creativity, improved self-esteem and kinesthetic empathy. In addition, DMT serves neurodevelopmental benefits to adolescents as well. Research shows that when implementing DMT or even a DMT based curriculum as an early intervention tool (especially in community-based settings), neuromaturation can occur which aids in the decrease of “risky” or

unhealthy coping behaviors developing into adulthood. (Rogers & Furcron, 2016). Research also shows that the shaping of important brain functions (i.e hippocampus, amygdala, and prefrontal cortex) imperative for youth development. According to the Academy of Pediatrics “50% of adults with mental health disorders experienced emergence of their symptoms by the age of 14 years” (AAP, 2021). DMT can aid in strengthening the relationship between neuromaturation, executive functioning, and neurodevelopment which support this development of healthy coping (Rogers & Fucron, 2016). This can include information processing, sensory processing, decision making, communication (verbal and non-verbal) and regulating emotions. DMT as a holistic approach not only serves as a tool to enhance social and psychological development, but also allows for creative exploration within self and the surrounding community. DMT can serve as a creative outlet for self-expression and self-discovery (Bernstein, 2019) which are pivotal aspects of adolescent development of character and autonomy. There is also the aspect of nonverbal and artistic communication vs the traditional talk therapy. The art of movement can reinforce positive relationships to the body along with strengthening its connection to our mind and our senses (Bernstein, 2019). According to Serlin (2020), “the arts heal by improving immune functioning and reducing stress and health complaints” (Serlin, 2020, p. 2), which DMT provides through a variety of psychotherapeutic mindful practices through the body. Whether in an individual or group setting, DMT makes room for healing and resiliency to take place simultaneously with authentic creative processing.

DMT with Adolescents Who Have Experienced Trauma. When introducing trauma recovery in DMT, the purpose is to center the approach of empowerment for the survivor and strengthening the mind-body connection (Berstein, 2019). This includes addressing the clients’ safety needs in order to reimagine a new and more positive experience in the body that differs

from what was experienced during the traumatic event (Bernstein, 2019). Specific research with only adolescent trauma is limited however according to the Movement Assessment and Treatment Manual for Trauma (MAMT), DMT practices for trauma recovery is broken down to three main categories; “illustrative (actions, emotions and cessation of movement), rhythmic gestures and regulative movements (repetition, comfort and cessation movements)” (Federman et al., 2019, p. 78-79). According to the MAMT, expressive nonverbal and verbal communications intertwining with the attunement of emotional responses as well as “body ownership” from the trauma experience is imperative in DMT trauma work (Federman et al., 2019). The current DMT props when working with trauma consist of primarily scarves, octabands, buddy bands and parachutes. The use of these props accompanied by this trauma framework can take multiple forms of creative expression of the body and evolve to sensory play to promote healing and reimagining finding safety within the body. The current popular non DMT treatment for adolescent trauma is cognitive behavioral therapy (CBT) however this approach is heavily based on the results of adult studies (APA, 2017). CBT has had a long-standing reputable reputation with individuals/groups who experience psychosis and have been exposed to trauma (APA, 2017). CBT application and approach centers around implementing manageable coping skills through redirecting behavioral patterns, problem-solving, increasing self-esteem, and providing insight to apply towards reality vs “distortions” in order to decrease psychological suffering (APA, 2017). The arts can be used as a tool to emphasize self-exploration and healing in a creative way all while incorporating psychotherapeutic approaches (i.e. problem solving, self-regulation, insight etc.). Specifically in expressive arts therapies, mindful practices meet emotional sensory processing through the creative modalities of music, art, dance/movement, poetry, or drama which can coincide with the same missions of CBT. This partnership is

understood to be an extension of how one can still obtain the goal of process and healing in CBT yet form an additional creative outlet to aid in that journey with a multitude of sensory mediums. In this case, a need of expansion in mediums with introducing dark and heavy materials to offer a more accurate representation within the psychotherapeutic journey.

Weights as an Intervention Tool

Sandbag weights or “weights” as tools have not been explored in the profession of DMT however they have been explored in other domains such as health and fitness. Weights have been popularly known to be used to target physique in fitness, strength and endurance. Other common uses of sandbags outside of health professions include industrial and construction use (to provide structure, lay foundations, prevent flood etc). Outside of these popular uses, sandbag weights have served as an important intervention tool for physical therapists (PT’s) and the military for decades. Dating back to World War I (1941), sandbags were used in the front lines for building barriers and protection against attackers (Bacdon, 1971). Its use increased during World War II (1939), with over 400 million in use then over 8 million use in the Vietnam War (1955), (Bacdon, 1971), making it wildly popular in combat. Currently, sandbag weights in the military are used in the similar fashion in addition to cover from intense climates (like floods or sandstorms) and physical fitness training (Bacdon, 1971). Rehabilitation and medical centers are widely known for the use of sandbag weights in physical conditioning. Modern physical therapy (also known as physiotherapy) origin dates to Europe in the 19th century however its establishment in the U.S became popular during World War I in the treatment of injured soldiers (Campbell, 2017). Physical therapy was later expanded in the use of muscle conditioning with polio patients (Campbell, 2017). Today, physical therapy is still an effective intervention used for physical rehabilitation including improving range of mobility, pain management including

chronic, injury rehabilitation, and preventative measure for risk of future injury and chronic diseases (APTA, 2020). When it comes to weight and strength training, physical therapist may use these weighted tools to expand muscle flexibility, relaxation and resistance to measure self-efficacy for post injury progress (Konin & Jessee, 2012). According to the Wall Street Journal, using sandbag weights promotes “unison” throughout the body to “work to balance and stabilize it” (Johannes, 2014) as oppose to traditional non shifting weights like dumbbells which “move in a predictable pattern” (Johannes, 2014); which may work against the fluidity that is authentic movement and play in DMT. In my past experience working with PT’s in a rehabilitation hospital as a rehab therapy aide, I have personally witnessed the success and self-efficacy with this strength-based approach as well as the level of resiliency shown by patients in trauma recovery. Acknowledging the limited approaches regarding treatment for young adolescent traumas, I propose to bridge a more holistic approach with psychotherapeutic DMT practices along with an autonomous process to allow clients to expressively assess the magnitude of their trauma. An expressive arts intervention can allow adolescents to creatively demonstrate autonomy of how they define their own experience including their intrinsic definition of resiliency and trauma (Van Katwyk & Seko, 2019).

Methodology

This study was conducted with seven students aged 8-11, members of the “Boys and Girls” club in Leominster, MA. Each participant engaged in group DMT sessions once a week for 45 minutes over the course of 4 weeks. Surrounding the theoretical framework of symbolic play - this thesis will introduce two props to be used that are on extremes of effort sensory spectrum (bright colored scarfs vs dark colored scarves and dark colored weights), in order to observe which ones the participants gravitated to as the more accurate representation of their

trauma. The intervention will be comprised of four stages; 1. Identifying trauma and/or stressor, 2. Moving through trauma pt. 1, 3. Moving through trauma pt. 2, 4. Choosing to define trauma (Please see Appendix 1).

Every participant that utilized the sandbag weights, chose a level weight (in the increment of five pounds increase from 1-20 pounds will be available) that was most representative of the magnitude of that trauma. Participants were invited to interact with their chosen symbolic trauma through expressive movement based on a piece of artwork they created in the initial start of the session identifying what they believed to be their prioritized traumatic event. Group processing and recording of information took place in the form of verbal group discussions with feedback, art making, audio recording and journaling observations from sessions. Onsite supervisor played the role of thesis consultant.

Results

After conducting this study, results showed majority participants gravitated towards the sandbag weights and dark colored scarves as opposed to light colored scarves. In the following description, it would be assumed that levels of Covid-19 related stress plays a dominant factor amongst current adolescents' trauma processing, however, there were a variety of topics discussed during these sessions of exploring recent trauma beyond Covid-19. Themes of participants' artwork created in week 1 consisted of recent family loss/near death experiences, witnessing pet loss, victim of school bullying and personal life changing impacts of Covid-19. Participants' artwork mediums included colored drawings, writing and origami. Major areas of discovery in study were resiliency, dark colored scarves and weights were preferred to describe trauma, light colored scarves chosen to describe when participants reached acceptance or hope,

color associations with objects involved in their trauma and the emergence of repressed trauma when working with the weights.

Resiliency

All 7 participants reported that they enjoyed this process of movement and art-based exploration. Descriptions such as “calm”, “fun”, “satisfying”, and feeling “not as sad” were used to describe the entirety of this 4-week process. All participants shared that having a strong support system such as family, friends and community programs such as the Boys and Girls Club of Fitchburg and Leominster, has helped them to adjust to their “new normal” after experiencing their trauma. 4 out of 7 participants felt a physical recollection of emotions which triggered responses of crying, shaking, and avoidant eye contact after movement but felt comfortable to continue closing discussions and to further participate in the study. All participants had some level of difficulties when trying to arrange the weights from out of their containers and were allowed assistance from a junior staff member should they need. 3 out of 7 participants refused to ask for help with responding “I got this”, “I’m strong”, “I can do it”, wanting to show levels of strength and self-efficacy. All participants reported that they will continue to engage with the same environment in which the traumatic event took place but did not feel the same intensity of emotions from the day of the event.

Equating dark colors and heavy weights to trauma

When choosing which prop best represented the participants’ overall trauma, 5 out of 7 participants chose dark colored scarves or weights. Specifically with the scarves, more black and blue scarves were chosen and as for weights, 15 pounds and 20 pounds were the popular choice. When asked to reflect why these properties were chosen, participants described it was best fitting

because their trauma put a lot of “weight” on their shoulders or responded that the “pain” they experienced from their trauma is “dark”. Movements with the dark colored scarves and weights consisted of either a full reenactment of the event/artwork or using the prop to represent who/what their artwork was about. 2 out of 7 participants expressed the way they maneuvered the props reminded them of reliving the event causing overwhelming emotions during closing share.

Equating light color scarves to acceptance

1 participant claimed they would have chosen the dark colored scarves but “light kills covid”, referencing reports he heard about UV lights as solutions to killing the virus. The same participant also stated that they would have liked to use both boxes of scarves (light and dark) to be representative to their covid experience: The participant designated light colored scarves as “happy colors” and dark colored scarves as “sad colors”. The participant shared that the scarves would be used to describe the cycle of emotions experienced with covid laying in the middle of the scarves reflective of the artwork from week 1.

The cycle created by the participant consisted of before lock-down (light); lock down including school changes and witnessing deaths and cases rise (dark); and learning of the distributions of vaccines (light). Another participant chose to create a “happy scenery” with the light-colored scarves to reflect the acceptance of their pet’s passing consisting of a meadow of flowers, clouds, sunlight and a lake. The participant represented the pets in white scarves together playing in their “happy” place. Each of these participants used the word “hope” to describe the ending process of this exploration with the bright colored scarves.

Color associations with objects present during their trauma.

All participants chose colors that were either used in their artwork or present at the time of traumatic event. These color associations were not limited to just one type of prop but applied to all props present (light scarves, dark scarves and weights). These symbolic items included school based and household items, a vehicle color, and colors depicted in artwork tied to emotion (specifically lime green equated to germs/fear of germs, red was anger and blue represented tears and sadness). During weeks 2-4 of movement exploration, each participant referenced their artwork at least once while in the therapeutic space checking to make sure their movement process was reflective of their work as well as emotions depicted.

The reemergence of additional trauma memories when working with weights

1 participant reported moving with the weights triggered an additional traumatic memory. Originally used in swinging motions side to side of the body, the participant took the 2 1 pound weights turning them to represent tears until slowing melting to the floor covering their face with the weights. Another participant reported during movement reflection with a 20 pound weight, memories of watching how their parent experienced the same trauma resurfaced. The participant reported she had difficulty processing the initial trauma however they were thankful for the parent's support however it was hard to watch parent process their emotions due to the event as well.

Wanting to ground the body with weights

5 out of 7 participants felt the need to put the weights on top of their body for self-regulation. Specifically, breath closures during week 3 and 4, participants utilized sandbag weight to lay on the floor claiming they needed to "relax" and "calm" their bodies after the

exertion of movement. Participants also reported satisfaction of piling the weights on their bodies in order to measure “strength” and to see how fast they could get that symbolic weight off of them. There were also observed pauses for breath in between shaking the weights off their body. Body parts observed in this grounding included face, legs, stomach and chest.

Discussion

Research in adolescent trauma is limited and so are the range of materials used to work with them. This study has shown the multiple benefits of expanding DMT props in order to meet sensory, emotional processing, and creative needs. With this thesis, participants were able to identify the impact of their trauma in a measurable and artistic way. Addressing grounding needs of the client, different sensory processing options, the expansion for movement dialogue in storytelling and sharing of embodied experience were very much present throughout this 4-week process. Some participants spent more time in the reflective stage to process and self-regulate due to ADHD diagnosis making their movement exploration sometimes 5-10 minutes shorter as compared to those who do not have a known diagnosis.

The primary limitations of this thesis were Covid safety related. Because of the covid-safety protocols, community engagement had to be adjusted to where participants worked independently and only engaged in movement sharing at least 6ft apart. Prop use were limited such as the octaband with only two people at a time and pausing to disinfect touched materials before the next use by someone else or if a participant wanted to go back swap out materials. During this time schools were also reintegrating into a hybrid model where some participants could only be present in the beginning of the week and others towards the end so regrouping and rescheduling of sessions occurred at least once a week.

This perspective of symbolic play would be beneficial to explore in DMT to not only witness but to invoke new concepts/ relationships to the body as adolescents move through and define their own trauma narratives. This level of autonomy uplifts the voices of minor clients in a therapeutic and creative way allowing them to physically process their own level of acceptance and resiliency. This could serve as a future assessment tool for clinicians to involve adolescent and minor clients in the intake process and provide insight to measurable progress all while remaining within ethical boundaries. This form of attunement and engagement could strengthen therapeutic rapport which research showed to be a key part in adolescents' autonomy in choosing to engage in healing processes.

REFERENCES

- American Physical Therapy Association (2020). *Benefits of physical therapy*.
<https://www.choosept.com/benefits/default.aspx>
- American Psychiatric Association. (2017). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- American Psychological Association. (2008). Children and trauma: Update for mental health professionals. <https://www.apa.org/pi/families/resources/children-trauma-update>
- American Psychological Association. (2013). Physiological and psychological impact of racism and discrimination for African-Americans.
<https://www.apa.org/pi/oema/resources/ethnicity-health/racism-stress>
- American Psychological Association. (2017). What is cognitive behavioral therapy?
<https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>
- Bacdon, V. J. (1971). Development of the long-life military sandbag. *Textile Research Journal*, 41(6), 549–549. <https://doi.org/10.1177/004051757104100610>
- Blaustein, M., & Kinniburgh, K. M. (2018). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency* (2nd ed.). Guilford Publications.
- Bretherton, I. (1984). *Representing the social world in symbolic play: Reality and fantasy*. *Symbolic play: The development of social understanding* (pp. 3–41). Academic Press.

- Campbell, B. (2018). *Past, Present, Future: A program development exploring Post Traumatic slave syndrome (PTSS) using experimental learning and dance/movement therapy based approaches* (Publication No. 104) [Masters thesis, Columbia College Chicago]. Creative Arts Therapies Theses. https://digitalcommons.colum.edu/theses_dmt/104
- Campbell, S. K. (2017). Physical therapy. In *Encyclopedia Britannica*.
<https://www.britannica.com/science/physical-therapy>
- Davis, M. (2018). *Play and Symbolism in Lowenfeld and Winnicott*. The Dr Margaret Lowenfeld Trust.
- Degrug, J. A. (2017). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*. Joy Degruy Publications.
- Ellis, R. (2001). Movement metaphor as mediator: A model for the dance/movement therapy process. *The Arts in Psychotherapy*, 28(3), 181-190. [https://doi.org/10.1016/S0197-4556\(01\)00098-3](https://doi.org/10.1016/S0197-4556(01)00098-3)
- Federman, D., Zana-Sterenfeld, G. & Lev-Wiesel, R. (2019). Body Movement Manual for the Assessment and Treatment of Trauma Survivors. *American Journal Dance Therapy* 41, 75–86. <https://doi.org/10.1007/s10465-019-09298-3>
- Green, E. J., & Myrick, A. C. (2014). Treating complex trauma in adolescents: A phase-based, integrative approach for play therapists. *International Journal of Play Therapy*, 23(3), 131–145. <https://doi.org/10.1037/a0036679>

- Hart, C., & Chesson, R. (1998). Children as consumers. *British Medical Journal*, 316(7144), 1600–1603. <https://doi.org/10.1136/bmj.316.7144.1600>
- Hess, R., & Goldblatt, I. (1957). The Status of Adolescents in American Society: A Problem in Social Identity. *Child Development*, 28(4), 459–468. <https://doi:10.2307/1125973>
- Johannes, L. (2014, March 3). Weightlifting with shifting sand. *Wall Street Journal*.
<https://www.wsj.com/articles/SB1000142405270230436070457941714144659>
- Konin, J. G., & Jessee, B. *Range of Motion and Flexibility*. In J. R. Andrews, G. L. Harrelson, & K. E. Wilk (Eds.), *Physical Rehabilitation of the Injured Athlete* (4th ed.; pp. 74–88), W.B. Saunders, 2012. <https://doi.org/10.1016/B978-1-4377-2411-0.00006-X>
- Kool, R., & Lawver, T. (2010). Play therapy: considerations and applications for the practitioner. *Psychiatry*, 7(10), 19–24.
- Lally, M., & Valentine-French, S. (2019). *Lifespan development: A psychological perspective*
- Levy, F. J. (2005). *Dance movement therapy: A healing art* (2nd ed.). National Dance Association an Association of the American Alliance for Health, Physical Education, Recreation, and Dance.
- McCarthy, D. Becoming the Storm: Using the Energy and Imagery of Symptoms in Play Therapy to Help Children Heal. *American Journal of Dance Therapy* 40, 113–137 (2018). <https://doi.org/10.1007/s10465-018-9274-8>
- National Child Traumatic Stress Network. (2018). Effects. <https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma/effects>

Rodgers, L., Furcron, C. The Dynamic Interface Between Neuromaturation, Risky Behavior, Creative Dance Movement, and Youth Development Programming. *American Journal of Dance Therapy* 38, 3–20 (2016). <https://doi.org/10.1007/s10465-016-9216-2>

Serlin, I.A. Dance/Movement Therapy: A Whole Person Approach to Working with Trauma and Building Resilience. *American Journal of Dance Therapy* 42, 176–193 (2020). <https://doi.org/10.1007/s10465-020-09335-6>

Tates, K., & Meeuwesen, L. (2001). Doctor–parent–child communication. A (re)view of the literature. *Social Science & Medicine*, 52(6), 839–851. [https://doi.org/10.1016/s0277-9536\(00\)00193-3](https://doi.org/10.1016/s0277-9536(00)00193-3)

National Child Traumatic Stress Network. (2008). Understanding traumatic stress in adolescents: A primer for substance abuse professionals. <https://www.nctsn.org/resources/understanding-traumatic-stress-adolescents-primer-substance-abuse-professionals>

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Appendix 1. Intervention Protocol

Xavia Hawkins

Location: BGCFL Dance Studio
Monday and Friday 3 groups
45 min each for 4 weeks

Group A: Monday intervention. Friday gym
Group B: Monday gym. Friday intervention
Warm up/Check in: aprx 10 min
Intervention: 25 min
Closure: 10 min

Week 1: *Identifying trauma/ and or stressor*

Obj. Participants will be given the opportunity to draw or creatively write about their most prominent struggle

Goal. Participants will successfully complete art work and identify traumatic event to work with for duration of study

Warm up: Bean bag body check in. Participants will check in about their day or any topic of choice and identify a body part that is tense and create movement for peers to mirror.

Intervention: Participants will engage in tension and release movement starting from lower extremities to upper including box breathing technique. Participants will create visual art most representative of a prevalent struggle or significant negative event they have faced. Participants will then transition to reflect and move their drawing in authentic movement within their squares.

Closure: Participants will share their somatic experience during art making NOT the specifications of traumatic event. End with box breathing tension and release.

Week 2: *Moving through Trauma pt 1*

Obj. Participants will have the opportunity to reflectively move through the trauma depicted from the first session with scarves.

Goal: Participants will actively engage in symbolic play with scarves based on artwork from previous session

Warm up: Participants will use octaband to introduce community engagement and the efforts of light and bright through group tension and release

Intervention: Participants will bring their art to life through symbolic play with scarves based on the art they created in previous session

Closure: Group discussion of somatic feelings and opportunity to show movement if participants feel comfortable. End with Octaband stretch and release

Week 3: *Moving through Trauma pt. 2*

Obj. Participants will have the opportunity to reflectively move through the trauma depicted from the first session with weights.

Goal. Participants will actively engage in symbolic play with weights based on artwork from first session

Warm up: Participants will engage in resistance pushing by moving heavy object across the studio (disarming the playground wall push model) targeting the breath

Intervention: Participants will bring their art to life through symbolic play with weights based on the art they created in previous session.

Closure: Group discussion of somatic feelings and opportunity to show movement if participants feel comfortable. Participants will utilize weight as an extension of the body in box breathing technique emphasizing regulation with freeze dance/movement to music

Week 4: Choosing to define trauma

Obj. Participants will have the opportunity to choose intervention prop to move through the trauma depicted from art work from week 1

Goal Participants will choose which expressive prop is most accurately representative to actively engage with for symbolic play based on their artwork from week 1.

Warm up: Participants will be given a scarf and weight to do body scan from lower to upper extremity encouraging creative exploration of how each prop travels up and down or around the body.

Intervention: Participants will have the opportunity to display autonomy in how they interact with trauma depicted in art from week 1 by choosing either scarves or weight for their symbolic play and authentic movement.

Closure: Group discussion of somatic feelings and opportunity to not only show movement if comfortable but why they chose either weight or scarf and give overall feedback of thesis experience.

Appendix 2. Intervention Tools



THESIS APPROVAL FORM

**Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Dance/Movement Therapy, MA**

Student's Name: Xavia Hawkins

Type of Project: Thesis

**Title: The Weight of Trauma: Exploring a New Method in Dance/Movement Therapy for
Trauma Processing with Adolescents**

Date of Graduation: 5/5/2021

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

Thesis Advisor: Dr Tamar Hadar, MT-BC