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**The implications of stillness in Dance/Movement Therapy and its Significance in the
Treatment of Obsessive-Compulsive Disorder: A Literature Review**

Capstone Thesis

Lesley University

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Dance/Movement Therapy

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The implications of stillness in Dance/Movement Therapy and its significance in the
treatment of Obsessive-Compulsive Disorder

Abstract

There is a large body of research showing that Exposure and Response Prevention (ERP) is an effective method for treating Obsessive-Compulsive Disorder (OCD). However, many individuals still might not improve after exposure and other behavioral approaches. Current research has explored the role of interoception in OCD and highlighted the need for addressing physiological experiences in treatment. Research shows that the population with OCD might experience more distress than the general population when engaging in states of rest (Gehrt et al., 2020). This literature review explored how stillness in Dance Movement Therapy (DMT) could be conducive in increasing an individual's capacity to sustain anxiety for more extended periods and help with treatment adherence. It was found that individuals with OCD experience separation from emotion/internal stimuli to logical thinking and that self-ambivalence lie at the core of the disorder. Experience of stillness, when employed appropriately in therapy, could provide a chance for integration and increase interoceptive awareness in those individuals. A theoretical framework was conceptualized, providing a structure for therapists to develop new interventions for this population.

Keywords: *stillness, interoception, Obsessive-Compulsive Disorder, anxiety, dance/movement therapy.*

Introduction

Obsessive-compulsive disorder (OCD) is currently defined by obsessions, which are recurrent distressing thoughts, and compulsions, defined as the acts (mental or physical) performed in order to temporarily lower the distress experienced (Taylor & Jang, 2011). Some of the central beliefs associated with OCD involve the intolerance of uncertainty, overidentification with thoughts, and a higher sense of responsibility for thoughts (Obsessive-Compulsive Cognitions Working Group, 2005). Hence, rumination can be an extremely stressful experience for this population, triggering high anxiety and preventing them from entering states of stillness or rest. That distress usually shows subtle signs in the body - shaking legs, fidgeting, muscle tension. Those signals are accessible for therapists to observe and invite more palpable forms of change, especially for professionals in Dance Movement Therapy (DMT). For instance, the Kestenberg Movement Profile (KMP) is an assessment tool in DMT that contains observation and description of body language associated with repulsion/attraction as well as when individuals are experiencing high states of anxiety (Kestenberg and Soissun, 1997, as cited by Amighi et al., 2018, p. 92).

Exposure and Response Prevention (ERP) has been the lead treatment for this population. However, fifty percent of the individuals might not get better after engaging in ERP (Hezel & Simpson, 2019). Recently, more studies have been associating the symptoms of OCD with a deficit in interoceptive awareness (Schultchen et al., 2019), defined as the identification and interpretation of internal body sensations. Those findings have been inviting the practice of mindfulness as a critical component of treatment.

Consequently, there has been an increased interest in understanding the implications of learning techniques that address sitting with unpleasant feelings and sensations for this population. A comparative study has found that OCD patients report more visual and self-focused thoughts, planning, restlessness, and negative thoughts than the general

population while engaging in resting states (remaining awake while keeping eyes closed and attempting to relax) (Gehrt et al., 2020).

Biondo (2019) suggests that DMT professionals embrace stillness in the therapeutic process, associating the experience of stillness with Israelstam's (2007) concept of the dialectical edge. A place where contrasting experiences coexist, such as devastation and excitement, fear and pleasure, growth and destruction (Israelstam, 2007). The author also connects the concept of stillness to Winnicott's theory of the good enough mother. The caregiver will attune to the infant's needs and gradually lessen this attunement (Winnicott, 1953, as cited by Biondo, 2019). By being presented with frustration and frustration tolerance, the individual experiences their first "dialectical edge" (Biondo, 2019, p. 116), expressed through play at the early stages of life. Versluys (2017) has found that adults with anxiety and obsessive-compulsive disorders present as less playful than the general population. Perhaps the ability to increase or invite moments of stillness and playfulness could be connected to the ability to bear frustration without engaging in compulsive behaviors.

The application of DMT for OCD has only been explored when pairing it with other comorbidities, such as health anxiety (Stahl, 2020) and Post-traumatic stress disorder (PTSD)(Cleary, 2018). The concept of stillness in DMT has been a recurrent but not adequately explored topic. As Caldwell (2004) stated, "As dance therapists, we make movement more meaningful and powerful when we support this oscillation between conscious movement impulse and conscious stillness impulse" (p.10). The author also associates tension in the body with an attempt to maintain stillness through a fixed sense of self. However, no articles were found exploring the use of stillness in DMT with specific populations and considering limitations and pathways in which stillness might be invited and held by the therapist. I'll identify and highlight the different needs in the population with

OCD, investigate what DMT approaches have addressed similar needs in the past, explore the role of interoception as it connects to stillness, the past studies on silence in therapy, and investigate how stillness could be useful for the population in this paper.

Literature Review

Defining OCD

The previous edition of the DSM had OCD in the category of anxiety-related disorders (DSM-4, American Psychiatric Association, 2000) until it gained its own category as Obsessive-Compulsive and Related Disorders in the most recent version of the DSM. OCD is characterized by the presence of obsessions and/or compulsions. Obsessions can be thoughts, urges, preoccupations, and/or images experienced as unwanted and ego-dystonic (intrusive) (5th ed.; DSM-5; American Psychiatric Association, 2013). Such obsessions are followed by compulsive behaviors or mental acts, usually called rituals, to reduce the anxiety caused by the obsessions (Taylor & Jang, 2011). The content of the obsessions varies, and sometimes it might present as worries that most people experience.

However, “the obsessive-compulsive and related disorders differ from developmentally normative preoccupations and rituals by being excessive or persisting beyond developmentally appropriate periods” (5th ed.; DSM-5; American Psychiatric Association, 2013, p. 235). Therefore, a diagnosis is made only when rituals significantly interfere with the individual’s functioning.

Landscape on OCD (historical contexts)

The symptoms of OCD can be found in historical documents since the 15th century. It was interpreted as someone who is “partially possessed by the devil” (Fornaro et al., 2009, p.2), especially in cases of intrusive thoughts considered blasphemous, sexual, or other contents considered taboo by the society in context (Fornaro et al., 2009). Progressively obsessive-compulsive (OC) symptoms started to be seen through a medical lens until Freud

published his papers on obsessional neurosis. He conceptualizes the symptoms as mechanisms of defense from an unbearable feeling or idea resultant from certain experience(s) in childhood. The experience itself would be forgotten or “dismembered” from its affective component, therefore this component would be displaced into something else completely unrelated to the event, but that would cause similar distress, and consequently, the urge to stop it would become the compulsion (Freud, 1909). Therefore the OC symptoms would result from unconscious conflicts where thoughts and actions were separated from the emotion initially contained in them (Allee, 2000).

With the birth of cognitive-behavioral theories, the focus has shifted to targeting the following dysfunctional beliefs commonly found in OCD: “(1) inflated responsibility; (2) overimportance of thoughts; (3) excessive concern about the importance of controlling one's thoughts; (4) overestimation of threat; (5) intolerance of uncertainty; and (6) perfectionism” (Obsessive Compulsive Cognitions Working Group, 1997). Studies have suggested that models that rely solely on dysfunctional thoughts might be ignoring other biopsychosocial factors that also affect OC symptoms (Taylor & Jang, 2011). Therefore, different dynamics such as social environment, relationship to caregivers, and neurological structures are also essential to be discussed.

Symptoms, Dynamics, and Characteristics of OCD

Obsessions “usually share an increasing 'anxious tension' before acting the compulsions (both behavioral and mental), followed by a brief sense of relief as they are carried out” (Fornaro et al., 2009). The term ritual is also utilized interchangeably with the term compulsion. Because the relief of the anxiety is so brief, the individual feels the need to perform it repeatedly, causing deep mental, emotional and physical distress. Types of responses to obsessions include but are not restricted to: checking (e.g., checking if doors were locked), washing (e.g., washing hands after touching something contaminated or after

being in contact with a person/experience perceived as contaminated), hoarding, ordering (including symmetry and arranging), cognitive neutralizing (e.g., saying a particular word or number that “cancels” the thought), obsessions related to aggressive, sexual or religious themes (Foa et al., 2002). Individuals with OCD then present with a constant state of unrest, be it physical, emotional, and/or mental, when facing situations that trigger a sense of uncertainty. Depending on the severity, the triggering events can become more and more frequent and casual, limiting one’s ability to move through life without experiencing constant distress.

Treatment for OCD

Exposure and Response Prevention (ERP) is currently the most utilized treatment for OCD. According to Mowrer (1939), the presence of anticipatory anxiety in the presence of the triggering stimuli - usually associated with painful or disgusting experiences - leads to an avoidance of it, through behaviors that temporarily reduce the anxiety. Paradoxically, the rituals only reinforce the fear and the use of rituals and avoidance. ERP exposes the individual to the triggering stimuli while they resist rituals, ideally “seeing through” the experience by sitting with the distress that is usually avoided. Similarly, if someone is afraid of public speaking because of anticipatory fear of embarrassing themselves, they might proceed with speaking in front of a crowd - even while experiencing high anxiety - and perhaps notice that the speech was not as embarrassing or terrible as they thought, building tolerance to the experience and to the physiological sensations of the anxiety it provoked. Repeated experiences such as those would teach the individual that they can “survive” the distress caused by that stimuli and learn that the feared outcome might not happen as often as they thought.

Although ERP is effective, it does not work with at least half of the individuals in treatment in the long term (Hezel & Simpson, 2019). Therefore, the use of mindfulness has

been explored as an essential component of treatment as well (Hertenstein et al., 2012; Zhang et al., 2021). Mindfulness can be defined as the intentional practice of bringing attention to moment-by-moment experiences in a non-judgemental way (Kabat-Zinn, 2005). In mindfulness, the intention is not to take action on what is being noticed but to slowly build a witness that observes things as they are. Although there's a lack of literature that specifically examines the role of stillness in the treatment of OCD, there's a small body of knowledge that examines the role of silence and interoception in therapy. And it might provide insight into the process of staying with uncomfortable emotions while resisting rituals in ERP. Similarly, resting states have been explored within this population and noted to be especially important when considering the role of mindfulness in the treatment of OCD (Gehrt et al., 2020).

Theoretical perspectives on OCD

Although the treatment for OCD has been dominated by cognitive-behavioral theories, psychoanalysis might offer insights into the etiology of the disorder from a developmental and relational perspective. As mentioned before, the primary source of distress in OCD comes from the content of beliefs or thoughts that are interpreted as factual or omnipotent, called thought-action fusion (TAF). This phenomenon is sometimes utilized interchangeably with magical thinking, which isn't exclusively an OCD symptom. There are numerous religious and cultural beliefs that other cultures might consider magical thinking. For instance, believing that words can change external circumstances is an accepted term in many religions, and the moral load of having "bad thoughts" in religions like Catholicism. Einstein and Menzies (2004) ran a study that targeted the role of magical thinking in OC symptoms. Although it did not involve a clinical population with OCD, they found strong correlations between magical thinking and TAF.

Meares (2001) points out that Freud and Piaget have conceptualized the phenomenon of magical thinking and attributed it to a specific phase in development. Before the age of

four, the child is still developing the capacity to differentiate between an inner world and an external world. The boundaries between self and others are not yet so defined. “In order to move beyond this conceptual stage, children must discover that there are other realities than one’s own” (Meares, 2001, p.296). Therefore, the author suggests that “The overprotection in theoretical terms, underlies magical thinking, involves parents accommodating to the child’s conception of others as extensions of self” (Meares, 2001, p.298). The experience of “optimal frustration,” failure, and/or frustration in relation to self objects, which most likely will be caregivers, becomes essential for the child to start to create those healthy boundaries that will help them to separate thoughts and inner experiences from external reality (Kohut, 1984, p.99). When taking this phenomenon to therapy, this space of initial frustration and potential for growth and formation of boundaries is only possible in the presence of a “dialectically attuned therapist,” someone who will hold the space for the client to experience their “dialectical edge” (Israelstam, 2007). Biondo (2019) associates this experience with the capacity of the therapist to embrace moments of stillness in dance/movement therapy, as they might provide fertile soil for growth and change.

Arzul & Cartwright (2016) also identify a similar concept that appears in several psychoanalytical theories. They propose that regardless of symptomology or content of obsessions, the reflective function or mentalization becomes a constant issue in this population. The author defines the reflective function as the ability to see mental events as one of the numerous possibilities for reality (Arzul & Cartwright, 2016, p.6) or as “holding mind in mind” (Fonagy et al., 2004, p.3). For instance, playing with imagination or pretending is something achieved developmentally, where the child is able to separate what’s being created from actual reality. The authors found that regardless of different perspectives, most theories touch on the idea of the reflective function being compromised, which might be seen as an underlying function in which magical thinking is originated. That can cause not

just the phenomena of TAF in OCD but also lead to symptoms related to the rigidity encountered in perfectionism.

Furthermore, Kempke and Luyten (2007) take on a broader lens and talk about the role of ambivalence in people with OCD. According to the authors, symptoms of OCD are a result of a difficulty to accept or integrate different substructures in someone's identity or "selves" (p.293). In an attempt to suppress undesirable aspects of self, the individual attempts to control other parts of the self that might represent morally wrong impulses. For instance, negative thoughts towards loved ones might be suppressed as prohibited or ego-dystonic and therefore become worse in content as the person keeps on stopping them. In classical psychoanalysis, this is attributed to the combination of a severe superego, followed by suppressing aggression in maladaptive ways, which would be seen as the rituals performed to cancel or neutralize such thoughts (Kempke and Luyten, 2007, p.293).

In object relations theory, the quality of the relationship of an individual with their caregivers (or the object) is what will define this person's urges later in life, "the object is contemplated as the place where drives are discharged or is an element that forcibly imposes limits to the incipient and immense omnipotence. It has always been controversial" (Sanfeliu, 2014, p.266). Therefore, an early contradictory parenting experience, which would result in an ambivalent attachment style, gives birth to a perspective that both self and environment are for the most critical and punishing (Kempke and Luyten, 2007). The urges in OCD become about avoiding ambivalence both internally and in the environment. A search for a more rational, thinking-oriented organization then becomes a natural way to prevent the experience of emotions and feelings, which might bring about a rigid bearing when facing ambivalence (Kempke and Luyten, 2007, p.294). The authors then conclude that self-ambivalence is at the core of OCD. It is characterized by an incapacity to integrate contradictory representations of self and others. The symptoms of OCD (overestimation of

danger, inflated responsibility, perfectionism, strong need to control thoughts, TAF, intolerance of uncertainty) come as a way to prevent ambivalence at any cost (Kempke and Luyten, 2007, p.300). Similarly, “Moral self-ambivalence is proposed to influence the misappraisal of unwanted intrusions as a threat to self-worth, and to underlie the impetus to use compulsions” (Ahern et al., 2015). Any intrusive thoughts are perceived as a threat to the individual’s identity, rather than just something randomly generated by the mind.

The authors above have primarily based the research on previous literature on the subject and single case studies. Therefore, the points on the origins of OCD coming from a particular parenting style are not easy to prove through evidence-based studies. However, those studies offer a comprehensive view of what might underlie some of the behaviors that mark the disorder. Those theories suggest valuable points on how ambivalence and the development of reflective functioning might be central points in forming identity and motivations for OC behaviors. Therefore, those studies highlight a few key elements to consider when looking for DMT approaches: ambivalence, boundaries between self and environment, and frustration tolerance.

DMT and OCD

Before talking about stillness, it is essential to recognize what methods in DMT have addressed OCD. The goal is to understand what other interventions might need to be considered and how stillness can play its role in the treatment. Although no articles directly connecting DMT to OCD were found, a few articles address some of the needs previously identified for this population.

In a quasi-randomized pilot study in Barcelona with 12 patients presenting with eating disorders, Savidaki et al. (2020) attempted to learn the effects of DMT in body image and alexithymia in eating disorders. The authors utilized both qualitative and quantitative methods and found out that DMT increased their body satisfaction and appearance evaluation

after twelve 90 minute sessions over 14 weeks. Interventions used by the author included breathing exercises and exploration with objects as forms of connecting with one's self and increasing body awareness through alternations of light, free, direct, and sustained movements. The authors explored limits/boundaries through the body by utilizing elastics and other objects that emphasized the body's physical limitations within the environment. There was also a space where individuals were invited to reflect on their associations with certain movement qualities in relation to their symptoms. Getting in touch with "strong feelings" was a shared experience after engaging in the DMT sessions (Savidaki et al., 2020), something fundamental in treating OCD.

Pass Erickson (2021) proposes a model for embodied identity development through DMT. The author defines identity as "one's subjective, experiential sense of self that develops over time" (p.203). Decisions and behaviors are seen as identity markers. Therefore having an internal sense of self is something that guides decisions. The author highlights that while identity development is achieved through logical thinking in cognitive theories, DMT can offer an approach for "bottom-up" identity formation/id assessment, precisely what individuals with OCD might lack. In their literature review, the author identifies this process as "an ongoing conversation between embodied self-awareness, conceptual self-awareness, and movement behaviors" (Pass Erickson, 2021, p.209). The first would happen through interoception and then be interpreted through one's desires, values, and conjectures of who they are. Therefore actions towards the environment would surge in response to that.

By addressing movement behavior and embodied self-awareness, dance/movement therapists might be able to invite a repatterning of the conceptual self. The author highlights the importance of yield-type behaviors as conducive for sensing one's body, emotions, and environment input (Pass Erickson, 2021, p.209). Yielding in dance/movement therapy can be approached with or perceived as stillness by allowing the body to rely on the surface

supporting it and let it rest. Similarly, Caldwell (2018) emphasizes in her practice the importance of contemplating automatic bodily functions as a form of understanding one's boundaries:

“our body's most fundamental building block, the cell, holds one of our most powerful contemplative metaphors: semi permeability(...) we can't afford to be either impermeable or boundaryless” (p. 30).

In individuals with OCD, this approach might be critical when considering the high reliance on the concept of self rather than on the self that experiences, moves, and reacts more intuitively to external stimuli.

Kestenberg Movement Profile (KMP) as an assessment tool

The KMP is a complex system of movement observation and analysis utilized by dance/movement therapists. It was developed by Judith Kestenberg with the intent to learn and reflect on “the ways in which movement patterns evolve within the context of development” (Amighi et al., 2018, p. 5). The tool is inspired by the Laban Movement Analysis system, further developed to be utilized in clinical practice to inform movement related to developmental, cognitive, and relational functioning. As Amighi et al. (2018) acknowledge, this tool might be used as a whole, or one might choose to target specific clusters of movement qualities that might be useful for a particular purpose.

For this population, it is relevant to highlight two categories of observation, called pre efforts and unipolar shape flow. Pre efforts are characterized by “movements that use an inner focus on muscle tension to attempt to control how a movement will be executed as well as an outer orientation to the task at hand” (Kestenberg and Soissun, 1997 as cited by Amighi et al., 2018, p. 92), also characteristic when an individual is in a high state of anxiety. Unipolar shape flow “provides the structure for the expression of emotions, particularly of attraction and repulsion” (Kestenberg and Soissun, 1997 as cited by Amighi et al., 2018, p. 92);

characteristic of one's interaction with the environment, the movements of relationships. Therapists can use these categories to develop a descriptive language surrounding action that relates to the experience of avoidance/repulsion and states high anxiety in the body. Since those are expected in individuals with OCD when engaging in experiences that cause distress, they could offer a framework for therapists to engage in body-based interventions for this population.

Stillness as Related to Interoception

Since no articles were found exploring stillness solely, the concept will be developed throughout this paper in relation to interoception. Stillness can be seen as silence, stagnation, a stopping point, a turning point, a space of reflection, an avoidance, comfort, a halt, when one finds a blockage on the path, a period to incubate, like a fetus growing in the mother's belly, a space where one does not know what to do, and for that stillness might be seen as a place of deep discomfort. Caldwell (2018) conceptualized a spectrum where movement is qualified on one end as automatic on the other end as voluntary. Voluntary encompassing creative, conscious, and unconstrained movement might represent one's choices and identity traces. Automatic represents the metabolic activity, the movements of survival and functioning, which are considered constrained and less conscious (p.89). It is possible to see that states of stillness in the body might be opportunities for listening to the automatic movements maintaining the body alive. In the body, even when movement has ceased, the internal movements that keep the body alive never stop and therefore might become more conscious or "louder" in states of stillness.

Noticing or becoming familiar with the internal movements helps the process of stillness to become more bearable or perhaps more meaningful. As the body stands still, the heart beats, the thorax expands with the inhalations and shrinks with exhalations, the blood flows through the veins. Perhaps that flow might be perceived more fiercely in certain body

parts than others. The muscles that never relax stay tight, regardless of whether it supports the posture one chose to be in or if it is to hold a concern that has been allocated somewhere in the body unconsciously. The notion of movement remains untouchable, even when the body looks still.

Being able to notice, identify and interpret bodily signals has been attributed to the concept of interoception. Gibson (2019) has highlighted that most benefits attributed to mindfulness and meditation practices rely on increasing interoceptive awareness (IA). According to the author, “Rather than trying to anchor scientific findings in a set of abstract and varied practices and techniques (e.g., mindfulness), it may prove more useful to anchor those findings in the body. Focused attention on internal signals is necessary to develop IA and to recognize emotions” (p.11). Gibson (2019) bases his literature review on attending to the differentiation of attentional styles in mindfulness practices. For instance, focused attention (FA) is one way to establish procedures that focus on the body and, therefore, might increase IA, leading to the use of the body as a source of anchoring to the present. That might cause a decrease in rumination and a learned ability to use the body as a source of information for one’s emotional states.

Dance/Movement Therapy and Interoception

The American Dance Therapy Association (ADTA) defines dance/movement therapy (DMT) “as the psychotherapeutic use of movement to promote emotional, social, cognitive and physical integration.” By utilizing the body as a source of wisdom, DMT professionals might find the concept of interoception a vital source for basing their interventions and understanding the neuroscience behind it. Hindi (2012) proposes that “by understanding the process of interoception and the psychological implications of attending to interoception dance/movement therapists may be better able to support healthy emotional processing, perception formation, and identity formation through interoception-focused interventions” (p.

130). The author emphasizes that much of the body's sensory data do not make their way to consciousness. Therefore by engaging in practices that aim toward bringing attention to involuntary movement, a person can then transmit that information to other parts of their brain and gain insight into that part of their body.

However, one might ask: why is it essential to gain information on functions that seem to be doing their job independently and keeping the body alive? Damasio (1999) asserts that emotions have body-based origins, therefore being able to note for instance that one's breath is shortened or that tension started to build on the shoulders, it might be the body informing that a certain emotion is arising, and when those signals are not always conscious, they could be misinterpreted and/or misplaced. Interoceptive awareness is highly connected with identity, as "these feelings all have a sensory, but also an affective, motivational aspect" (Craig, 2002, p. 656).

Hindi (2012) also highlights the works of pioneers in the field of DMT, such as Blanche Evan, emphasizing the need to increase awareness of the spine as a form of preparing oneself for the therapeutic work. Although Evan might not have been aware of the neuroscience behind interoception, the understanding of the spine as a nest of nerves that bridges automatic bodily functions with more conscious processes in the brain was there intuitively. Seeing the spine as a bridge from unconsciousness to consciousness. The author suggests a structure in which DMT practitioners could apply this concept in therapy: (1) Establishing curiosity, (2) Identifying and tracking physical sensations through breathing and attending to different body systems, (3) Translating into communicable language, (4) Recognizing patterns, and (5) Exercising new awareness (Hindi, 2012, p. 136).

Interoception and OCD

Although the increase of interoceptive awareness is something found to be beneficial for healthy populations, there are concerns regarding populations that might already

experience a heightened reaction to bodily sensations. Bragdon et al. (2021) assembled from PubMed a literature search to investigate studies on interoception in OCD or obsessive-compulsive symptoms. The authors found different dimensions of measuring interoception, two of them were interoceptive accuracy (IAcc) which “reflects the objective perceptual accuracy of interoceptive states” (p. 3), and interoceptive sensibility (IS), which is a subjective assessment of how the internal body signals are appraised, regulated, and impact behavior” (p.3). Results have found an increased IS in people with OCD, and that was associated especially with increased severity in “not just right” feelings, responsibility for harm and fear of contamination (disgust) symptoms. Along with that, it was noticed more maladaptive responses to this increased IS, such as avoidance and excessive worry about uncomfortable sensations. IAcc results remained uncertain because of conflicting results from different studies.

The study also found the correlation of disgust proneness to interoceptive processes, especially because of its connection with the insula activation. Not surprisingly, it was found that compared with control groups, OCD individuals presented a higher activation of the insula when staring at disgust-inducing images. The authors conclude that “interoception may be more relevant to specific clinical presentations, including individuals with symptoms of symmetry/ordering motivated by sensory phenomena or contamination/washing driven by visceral feelings of disgust” (Bragdon et al., 2021, p. 8). Similar to OCD, individuals with PTSD also present with similar concerns when it comes to noticing and attending to body sensations, especially when considering the activation of the fight or flight mode due to the content of thoughts or triggering stimuli. Dieterich-Hartwell (2017) proposes a model for DMT in individuals with PTSD where interoception is central by first addressing safety, then regulating hyperarousal through “up” and “down” regulation movement, and finally attending

to interoception, one of the functions being to “educate client about need to at times endure uncomfortable sensations in order to make progress in recovery”(p.44).

Another study conducted with 26 OCD patients has found attenuated IAcc levels compared to the control group. Those were not improved over 8 to 10 weeks of cognitive-behavioral therapy (Schultchen et al., 2019). The authors emphasize an interesting model for understanding OCD symptoms. People with OCD dwell on “top-down” predictions or assumptions about body sensations and external input, which can lead to “bottom-up” prediction errors, perceived as having to be suppressed. Therefore, thoughts/interpretations of bodily sensations might conduct a specific behavior/impulse, which makes interoceptive signals become a source of anxiety and mistrust - the body becomes an unreliable source. The need for reassurance from external sources or logic statements becomes a dependency. For example, for folks with OCD, to decide if they like someone comes much more from a place of “does it make sense to like this?” or “what elements of this relationship make it likable/enjoyable according to societal norms I have learned?” rather than, “does this person make me feel good?” or “how do I usually feel when I’m around them?”(Schultchen et al., 2019).

Similarly, it was found that “individuals with OCD have attenuated access to and reduced confidence in their internal states, and that this deficit is specific to OCD and not attributable to anxiety” (Lazarov et al., 2014). If the body is a place of mistrust, it might be understandable that the source of identity for individuals with OCD might be much more reliant on external sources than on personal assessments of oneself, bringing the conversation back to the notion of identity in OCD and the issues with accepting ambivalence and separating self from environment.

Stillness/Silence in Therapy

Artistic Process and Silence

Although there's a lack of studies on stillness, some research investigated what might be the role of silence in the context of psychotherapy. Regev et al. (2016) explored the role of silence in art therapy by analyzing qualitative, semi-structured interviews with ten participants engaged in art therapy for at least four months. The interviews were structured with questions about the client's experience of silence, the role they imagined the art therapist must have in moments of silence, the impact of those experiences in the therapeutic relationship, and the role of art during the moments of silence in therapy. The results showed that silence was experienced as positive when it invited the opportunity for introspection and self-reflection, for instance during the art-making, when taking moments to look at the artwork, and in moments of release when there was a need to cry. The silence was always welcomed when engaging in the creative process, as it allowed, once more, for the clients to get in touch with themselves and engage in what they were doing.

On the other hand, the silence was perceived as a negative experience in the first weeks/months or the first few minutes of every session. It was also noted that silence was perceived as disruptive when there were no art materials present or no intent to engage in a creative process. So stillness in DMT could be perceived as fertile if individuals are offered a platform that participates in a creative process, instead of art materials, that could be seen as the music or a direct prompt the therapist might provide to that context.

This study is limited in its sample size, and eight out of ten participants were also studying to become art therapists. It would be interesting to learn from a population that might not necessarily be as familiar or comfortable with art-making. Another question this study raises is if having silence as a negative experience would carry any therapeutic benefit in the future. Especially considering the population targeted in this paper, where exposure to

anxiety-provoking experiences is precisely part of the treatment. For instance, the silence between client and therapist in cases where OCD is related to fears of engaging socially with others could become an interesting form of exposure.

Silence, Time and Space

Gans & Counselman (2000) explored the use and function of silence in therapeutic groups. As they point out, there's a constant dilemma experienced in group therapy between becoming part of the group or maintaining one's individuality. Although silence in groups can become an anxiety-provoking experience, especially in societies that cultivate a culture of rush and constant activity, "silence can be a precious gift of time and space in which to find oneself" (Gans & Counselman, 2000, p.74).

The authors go further into identifying, through various case examples, five different sources of silence: a) situational factors, being the most obvious to identify, usually due to a particular interruption, a group member's absence, a new group member or other external factors that might interfere to the course of the group, and the silence happens as a clue that the group needs a "reset" or restart in order to move on; b) individual dynamics, referred as the "requirements" or impositions that might be internalized by members of the group, revealing possible projections that might be made by members in the face of silence or that might create silence amongst certain members; c) member-member interactions, which might also be a product of projective identification or transference, where unspoken negative feelings towards members of the group might also result in some sort of "confused silence" (p.78); d) whole group dynamics, involves the consideration of developmental stages of a group, for instance if a new member comes in to a group that had already developed trust, silence might indicate a regression into the initial phases in response to that, similar experiences can happen in termination phases or when situations invite group to reorganize what the group might offer them; e) leadership related phenomena, which refers to problems

that might come from members seeing signs of “failure” in the group leader, which could be from an unmet need the leader might have not noticed, or from not owning limitations that might be pointed out in confrontations (Gans & Counselman, 2000).

Although the authors did not specify the populations and used a more generalized approach to the context of therapeutic groups, this study points out mainly the different ways in which silence might indicate an issue or a place for growth within the group. Silence doesn't always need to be filled. When it isn't, although it might not necessarily bring a sense of comfort, it might open space for unspoken issues to be addressed, possibly opening opportunities for milestones in the therapeutic process and the relationship among members and leaders of the group.

Obstructive Silence

Levitt (2001) utilized a qualitative approach to explore the experiences of obstructive silence in therapy. Four therapists of varied therapeutic orientations and seven of their clients with varying degrees of depressive symptoms participated in interpersonal process recall (IPR) interviews. The clients watched their own therapy session with the interviewer, while the recording would be stopped at different silent moments, and interviewees would be asked in a semistructured format to comment on their experience during those moments. A grounded theory approach was utilized, so the content of the interviews was segmented into meaning units. Two main categories of silence were identified by clients as obstructive: a) disengaged pauses, found when clients described being emotionally disengaged from the topic, trying to avoid a distressing emotion or “shutting down” in response to a triggering subject; and b) interactional pauses, concerning the client's thoughts on the therapist's process, wondering if they were bored of listening to them or if they could take the emotional load of the client. The former also happened when clients would not connect with some instruction from the therapist but did not want to jeopardize the therapeutic relationship,

choosing to remain in silence until they found a way to come up with something that would satisfy the relationship. Therefore compromising the client's authentic presence in therapy (Levitt, 2001).

This study lacked insight on possible differences in various social identities that could also play a role in the dynamics of silence in therapy. Especially when thinking about the interactional pauses category, it would be necessary to understand when there are cultural differences, including first language, ethnicity, socioeconomic status, race, gender, sexual orientation, etc. There are plenty of ways in which clients with identities that differ from their therapist might feel like they cannot explain themselves or verbalize their issues in therapy. For instance, it was found in a sample of 715 residents receiving intensive residential treatment that OCD symptoms are significantly higher “at both admission and discharge, the more marginalized identities an individual holds” (Wadsworth et al., 2020). On the other hand, the author posits a valuable point when discriminating between the possible meanings in silence. Therapists can address those moments and perhaps encounter more opportunities to grow the relationship and understanding between therapist and client. Consequently, helping clients to feel safer and welcome to be themselves.

Discussion

The explorations in silence and obstructive silence in therapy invite a few options of how the therapist might interact with stillness. For instance, when the goal is for the therapist to sit with stillness as it is happening naturally, they are, for the least, the “dialectically attuned therapist” (Israelstam, 2007) who does not fill the space or holds it immediately for the client. Leaving room for their own ambivalence to exist. In another instance, the therapist might be giving permission or inviting the individual not to decide immediately to recur to maladaptive behaviors such as avoidance and rituals but first to notice what might be the urge internally. In this case, moments of stillness can be important for increasing the person's

habituation to this place of uncertainty and discomfort and foster an opportunity for growth from an experience of frustration that is not “filled” by anything or anyone (Winnicott, 1953, as cited by Biondo, 2019).

Another more active form of engaging in stillness would be to invite awareness to interoception or to engage in the yield-type behaviors mentioned by Pass Erickson (2021, p.209). Perhaps the therapist might guide stillness by first noticing/naming the fidgets/small self-soothing movements and by gaining more awareness of what those movements are fulfilling at that moment. Acknowledging and asking what might be happening internally could invite 1) the notion that there’s a movement happening regardless of stillness and 2) exploring what’s being avoided in the first place without moving immediately to what will make that discomfort go away.

Therefore, there’s room for exploring habitual movement and might be considered rigid if that’s the only way one might choose to express themselves - which has been noticed in this paper as the place people with OCD tend to gravitate towards. The therapist might utilize movement observations such as KMP specifically by looking at pre efforts and unipolar shape flow movements, as it was documented as an example in Table 1, and that are associated with sometimes unconscious representations of reactions to anxiety, avoidance, repulse (Kestenberg and Soissun, 1997 as cited by Amighi et al., 2018, p. 92). By encouraging and inviting stillness, the therapist forms a possibility for individuals to experience staying with experiences of frustration/discomfort without falling into immediate action, and to gain a deeper awareness of interoceptive states (which for this population could be a cue the therapist can give as a way to invite the person’s interest, exploration, and endurance in the state of stillness). Theoretically, that would lead to what the body has to say, which could be an emotion that has been repressed, or to the exploration of identity through new perspectives. By staying with this element of uncertainty without taking action, the

individual could eventually move into more expressive movement, where there's room for authenticity, spontaneity, and flexibility (ambivalence is welcome).

Synthesizing the Literature

When exploring the needs of the OCD population through multiple lenses, it is highlighted a separation of emotion/internal stimuli from logical thinking (Kempke & Luyten, 2007; Schultchen et al., 2019). In other words, there's a tendency to give preference to pre-made or "external" rules instead of the body's wisdom. At the same time, there's a high sensitivity, or even one could say an intolerance to internal stimuli connected with unpleasant feelings. Which enters the field of interoception and how it can be considered a valuable function to be addressed and incorporated in DMT (Hindi, 2012). As most interventions for OCD end up not addressing sensory-related symptoms (Bragdon et al., 2021, p.8), dance/movement therapists can have an essential role in the treatment of those individuals.

Ambivalence was also found to be a central feature of OCD, where uncertainty and/or ambiguity are not tolerated in either self or in the environment (Kempke & Luyten, 2007). Particularly observed in symptoms of perfectionism. Additionally, the reflective function was a concept utilized in several theories that aim to understand the etiology of OCD (Arzul & Cartwright, 2016). This concept was associated with the phenomena of magical thinking, or TAF, and attributed to developmental stages where an individual starts to separate self from the environment and the inherent need to experience "optimal frustration" (Winnicott, 1953, as cited by Biondo, 2019), moments where one starts to learn their thoughts do not always reflect on the environment. That experience is only possible in the presence of a "dialectically attuned therapist" (Israelstam, 2007), whose ability to encourage and give space for stillness might allow for a space where ambiguity and uncertainty might be supported (Biondo, 2019), something that can be richly explored through the practice of DMT.

In the case of OCD, sitting in this space which could be called a dialectical edge, could mean both experiencing discomforts of internal sensations and gaining more embodied awareness. A place of pause and engaging with the experience of uncertainty and the experience of self as ambiguous without running back into action, into certainty. A place where the individual might experience more sides of self, which includes accepting and experiencing the range of emotions that cause distress in the body. Letting them be there and watching them go, as mindfulness practices similarly emphasize (Kabat-Zinn, 2005).

Towards a New Theoretical Understanding

A spectrum of movement emphasizing that idea was created (Image 1), wherein one end there's the experience of "habitual movement," which might be a movement that is done for a reason and that "makes sense" from a rational perspective. Also associated with maladaptive ways to deal with anxiety, in OCD would be considered the rituals and avoidance behaviors. This kind of movement fulfills the role of certainty. Once one experiences the beginning of uncertainty, in the case of OCD, the triggering experience, they might return to the safety of a rational and linear understanding of themselves. As Caldwell (2004) associates tension in the body with an attempt to maintain stillness through a fixed sense of self, it could be seen as the individual's attempt to cease experiences of ambivalency by recurring to rituals that will give a temporary version of themselves that is assertive and "safe", but that might restrain all the other possibilities for this person to experience themselves. Pre efforts and unipolar shape flow observed in patients through the KMP would belong somewhere in between, where the individual is starting to react to the experience that causes uncertainty. Therefore, the therapist can observe and address movements of fidgeting, straining, and so on, as provided in examples in Table 1. If those movements of reaction are noticed, invited, and attention is brought to the body, then stillness could be the moment to remain in the experience without recurring to compulsions. Finding stillness would be helpful

for the individual to eventually make choices more oriented towards creative movement - which would be less about a notion of self and more related to a conscious but still spontaneous choice of what one wants, who they choose to be in that moment, what they choose to do rather than what makes sense to do. In this sense, stillness could be utilized as a passage of the individual from avoidance into a place of integration, acceptance, and coexistence with self ambivalence.

From a neurological point of view, increasing awareness of interoceptive activity enhances one's capacity to notice and withstand a wider range of emotions (Damasio, 1999). As it is being conceptualized in this paper, it also pertains to the ability to possibly perform ERP and sustain the anxiety caused by it. The spectrum presented in Figure 1 might offer a starting point in how DMT can be approached in this population and formulate a treatment that starts from the point of meeting the individual in their comfort and lead the movement into a place of authenticity and integration.

Figure 1

Movement Spectrum as a Theoretical Framework for DMT in OCD treatment

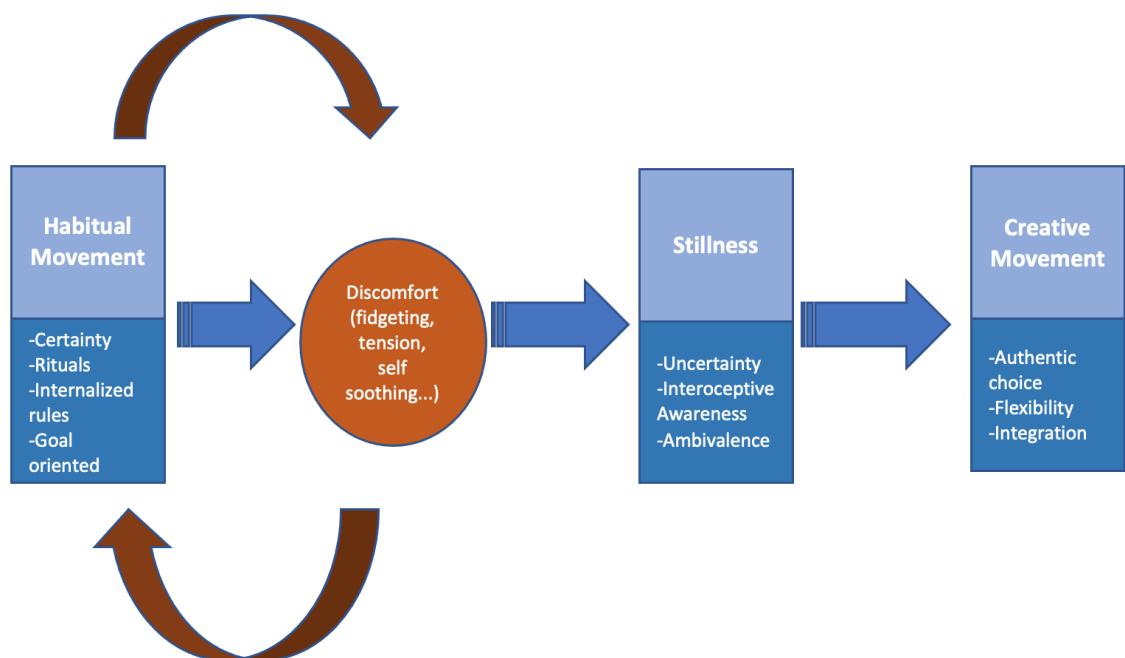


Table 1*Observation of movement through KMP in patients during ERP*

Pre-efforts	Movements observed	Stimuli
Channeling (dividing/separating/ isolating)	Stopping experience to explain why feeling uncomfortable, rationalization, goal oriented movement	Reading script, engaging in casual conversation, attempting to move spontaneously with music
Straining (high intensity + bound flow)	Making fist, tensioning face/shoulder muscles, fidgeting/pressing elbows in hand	Watching triggering videos, reading script, sharing something personal
Sudden (abrupt change in tension + accelerate - false notion of fast)	Spasms in arms, chest, shoulders, moving away (backwards)	Touching contaminated surfaces, watching triggering videos
Hesitation (gradual change in tension + decelerate)	Light touch, lowering/lightening voice, avoidance (speaking instead of doing what was asked), long pauses on speech	Touching contaminated surfaces, saying ITs (intrusive thoughts) out loud, engaging in conversation
Unipolar shape flow	Movement observed	Stimuli
Lateral Narrowing	Moving torso away, "disgust" expression	Engaging in casual conversation, watching triggering videos
Shortening Up	Lifting one shoulder and head, moving away from stimuli	Watching triggering videos
Bulging forward	Moving torso and head towards stimuli	Engaging in conversation w/ therapist

Limitations/challenges

Although it was mentioned a few times throughout this article that experiences of intersectionality in the treatment of OCD need to be considered, this research did not incorporate that accordingly, due to the already lacking research in the theme of stillness. However, the points made on obstructive silence (Levitt, 2001) are important for understanding with more depth when is stillness/silence touching on a place of misunderstanding, especially when thinking about populations that are misrepresented in

studies involving OCD. When thinking about the offer of space for uncertainty, this uncertainty needs to come with the intention of growth and not to create more confusion and/or feelings of being misunderstood by people of marginalized identities.

Recommendations for Future Research

Future directions should move beyond creating a method that explores both how a therapist might respond to stillness and how that might reverberate in the therapeutic relationship for this population. Especially creating paths or specific interventions that would invite stillness in a helpful format for the population explored in this paper and considering the role of intersectionality in treatment. It will be essential to understand what underlies a fertile versus an obstructive perception of stillness. The spectrum proposed in this literature review can provide a structure to treatment oriented explicitly towards the OCD population.

Conclusion

The treatment for OCD contains already established and well-researched methods in use. However, more attention needs to be put on the physiological aspects of OCD as they interact directly with the symptoms and how treatment might be approached. Dance/movement therapists have the expertise to address those, especially when thinking about the function of interoception in treatment and how DMT interventions can be created to assist the progress of embodied awareness. Although not well researched in DMT, the concept of stillness is understood in this paper as an intrinsic factor for the development of interoception and toward a more integrated experience of self.

References

- Allee, JG. (1997) The rat man. Cognitive assessment of obsessive-compulsive disorder. Obsessive-Compulsive Cognitions Working Group. *Behav Res Ther.* 35(7):667-81. doi: 10.1016/s0005-7967(97)00017-x. PMID: 9193129)
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- American Psychiatric Association. (2000) *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)*. Washington, DC, USA.
- Amighi, J. K., Loman, S., & Sossin, K. M. (2018). *The meaning of movement: Developmental and clinical perspectives of the Kestenberg Movement Profile*. Routledge.
- Kohut, H. (1984). *How Does Analysis Cure?* Chicago, IL: University of Chicago Press.
- Sanfeliu, Isabel. *Karl Abraham: The Birth of Object Relations Theory*, Taylor & Francis Group, 2014. *ProQuest Ebook Central*, <http://ebookcentral.proquest.com/lib/lesley/detail.action?docID=1684465>.
- Obsessive-Compulsive Cognitions Working Group. (2005). Psychometric validation of the Obsessive Belief Questionnaire and Interpretation of Intrusions Inventory: Part 2. Factor analyses and testing of a brief version. *Behaviour Research and Therapy*, 43, 1527–1542. doi:10.1016/j.brat.2004.07.010
- Damasio, A. R. (1999). *The feeling of what happens; body and emotion of making consciousness*. Orlando, FL: Hartcourt.
- Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., Salkovskis, P. M. (2002). The Obsessive-Compulsive Inventory: Development and validation of a short version. *Psychological Assessment*, 14, 485–495. doi:10.1037/1040-3590.14.4.485
- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2004). Affect regulation,

- mentalization, and the development of self. New York: Other Press.
- Kabat-Zinn J: Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness. 15th edition. New York, NY US: Delta Trade Paperback/Bantam Dell; 2005.
- Mowrer, O. H. (1939). A stimulus-response analysis of anxiety and its role as a reinforcing agent. *Psychological Review*, 46 (6), 553-565.
<https://doi.org/10.1038/nrn894>
- Damasio, A. R. (1999). The feeling of what happens; body and emotion of making consciousness. Orlando, FL: Hartcourt.
- Ahern, C., Kyrios, M., & Moulding, R. (2015). Self-Based Concepts and Obsessive-Compulsive Phenomena. *Psychopathology*, 48(5), 287–292.
<http://dx.doi.org/10.1159/000437333>
- Arzul, J.-P., & Cartwright, D. (2016). The reflective function in obsessive-compulsive disorder. *Psycho-Analytic Psychotherapy in South Africa*, 24(1), 1–38.
- Biondo, J. (2019). Stillness in Dance/Movement Therapy: Potentiating Creativity on the Edge and in the Void. *American Journal of Dance Therapy*, 41(1), 113–121.
- Bragdon, L. B., Eng, G. K., Belanger, A., Collins, K. A., & Stern, E. R. (2021). Interoception and Obsessive-Compulsive Disorder: A Review of Current Evidence and Future Directions. *Frontiers in Psychiatry*, 12, 1471.
<https://doi.org/10.3389/fpsy.2021.686482>
- Caldwell, C. (2004). American Dance Therapy Association 38th Annual Conference Keynote Address: The Power of Stillness, the Glory of Motion. *American Journal of Dance Therapy*, 26(1), 9–15. <http://dx.doi.org/10.1023/B:AJOD.0000031799.93633.96>
- Cleary, M. E. (2018). *Obsessive Compulsive Disorder and Posttraumatic Stress Disorder in Adults: Analysis of Their Relationship in Treatment and How Dance Movement*

Therapy Can Play a Role. 39.

Craig, A. D. (2002). Opinion: How do you feel? Interoception: the sense of the physiological condition of the body. *Nature Reviews Neuroscience*, 3(8), 655–666.

<https://doi.org/10.1038/nrn894>

Dieterich-Hartwell, R. (2017). Dance/movement therapy in the treatment of post-traumatic stress: A reference model. *The Arts in Psychotherapy*, 54, 38–46.

<https://doi.org/10.1016/j.aip.2017.02.010>

Einstein, D. A., & Menzies, R. G. (2004). Role of magical thinking in obsessive-compulsive symptoms in an undergraduate sample. *Depression & Anxiety (1091-4269)*, 19(3),

174–179. <https://doi.org/10.1002/da.20005>

Fornaro, M., Gabrielli, F., Albano, C., Fornaro, S., Rizzato, S., Mattei, C., Solano, P.,

Vinciguerra, V., & Fornaro, P. (2009). Obsessive-compulsive disorder and related disorders: A comprehensive survey. *Annals of General Psychiatry*, 8, 13.

<https://doi.org/10.1186/1744-859X-8-13>

Freud, Sigmund (1999). The standard edition of the Complete Psychological Works of Sigmund Freud: Two Case Histories ('Little Hans' and the "Rat Man") (Vol. 10) (A. Freud & J. Strachey, Trans.). London. The Hogarth Press. (Original work published in 1909).

Gans, J. S., & Counselman, E. F. (2000). Silence in group psychotherapy: A powerful communication. *International Journal of Group Psychotherapy*, 50(1), 71–86.

Gehrt, T. B., Frostholm, L., Pallesen, K. J., Obermann, M.-L., & Berntsen, D. (2020).

Conscious thought during the resting state in patients with severe health anxiety and patients with obsessive-compulsive disorder. *Psychology of Consciousness: Theory, Research, and Practice*, 7(3), 207–217. <https://doi.org/10.1037/cns0000256>

<https://doi.org/10.1037/cns0000256>

Gibson, J. (2019). Mindfulness, Interoception, and the Body: A Contemporary Perspective.

- Frontiers in Psychology*, 10, 2012. <https://doi.org/10.3389/fpsyg.2019.02012>
- Hertenstein, E., Rose, N., Voderholzer, U., Heidenreich, T., Nissen, C., Thiel, N., Herbst, N., & Klz, A. K. (2012). Mindfulness-based cognitive therapy in obsessive-compulsive disorder—A qualitative study on patients' experiences. *BMC Psychiatry*, 12(1), 185–194. <https://doi.org/10.1186/1471-244X-12-185>
- Hezel, D. M., & Simpson, H. B. (2019). Exposure and response prevention for obsessive-compulsive disorder: A review and new directions. *Indian Journal of Psychiatry*, 61(Suppl 1), S85–S92. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_516_18
- Hindi, F. S. (2012). How Attention to Interoception Can Inform Dance/Movement Therapy. *American Journal of Dance Therapy*, 34(2), 129–140. <https://doi.org/10.1007/s10465-012-9136-8>
- Israelstam, K. (2007). Creativity and dialectical phenomena: From dialectical edge to dialectical space1. *International Journal of Psychoanalysis*, 88, 591–607.
- Kempke, S., & Luyten, P. (2007). Psychodynamic and cognitive-behavioral approaches of obsessive-compulsive disorder: Is it time to work through our ambivalence? *Bulletin of the Menninger Clinic*, 71(4), 291–311.
- Lazarov, A., Liberman, N., Hermesh, H., & Dar, R. (2014). Seeking proxies for internal states in obsessive-compulsive disorder. *Journal of Abnormal Psychology*, 123(4), 695–704. <https://doi.org/10.1037/abn0000004>
- Levitt, H. M. (2001). Clients' Experiences of Obstructive Silence: Integrating Conscious Reports and Analytic Theories. *Journal of Contemporary Psychotherapy*, 31(4), 221.
- Meares, R. (2001). A Specific Developmental Deficit in Obsessive-Compulsive Disorder: The Example of the Wolf Man. *Psychoanalytic Inquiry*, 21(2), 289. <https://doi.org/10.1080/07351692109348936>

- Pass Erickson, L. M. (2021). Sensing the self: A dance/movement therapy model of embodied identity development. *Body, Movement and Dance in Psychotherapy*, *16*(3), 202–217. <https://doi.org/10.1080/17432979.2020.1850524>
- Regev, D., Chasday, H., & Snir, S. (2016). Silence during art therapy—The client's perspective. *The Arts in Psychotherapy*, *48*, 69–75. <https://doi.org/10.1016/j.aip.2016.02.001>
- Savidaki, M., Demirtoka, S., & Rodríguez-Jiménez, R.-M. (2020). Re-inhabiting one's body: A pilot study on the effects of dance movement therapy on body image and alexithymia in eating disorders. *Journal of Eating Disorders*, *8*, 1–20. <http://dx.doi.org/10.1186/s40337-020-00296-2>
- Schultchen, D., Zaudig, M., Krauseneck, T., Berberich, G., & Pollatos, O. (2019). Interoceptive deficits in patients with obsessive-compulsive disorder in the time course of cognitive-behavioral therapy. *PLoS ONE*, *14*(5), 1–13. <https://doi.org/10.1371/journal.pone.0217237>
- Stahl, K. (2020). *Mindfulness-based Dance/Movement Therapy for Obsessive-Compulsive Disorder and Health Anxiety: Development of a Method*. 37.
- Taylor, S., & Jang, K. L. (2011). Biopsychosocial etiology of obsessions and compulsions: An integrated behavioral–genetic and cognitive-behavioral analysis. *Journal of Abnormal Psychology*, *120*(1), 174–186. <https://doi.org/10.1037/a0021403>
- Versluys, B. (2017). Adults with an anxiety disorder or with an obsessive-compulsive disorder are less playful: A matched control comparison. *The Arts in Psychotherapy*, *56*, 117–128. <https://doi.org/10.1016/j.aip.2017.06.003>
- Wadsworth, L. P., Potluri, S., Schreck, M., & Hernandez-Vallant, A. (2020). Measurement and impacts of intersectionality on obsessive-compulsive disorder symptoms across intensive treatment. *American Journal of Orthopsychiatry*, *90*(4), 445–457.

<https://doi.org/10.1037/ort0000447>

Zhang, T., Lu, L., Didonna, F., Wang, Z., Zhang, H., & Fan, Q. (2021). Mindfulness-Based Cognitive Therapy for Unmedicated Obsessive-Compulsive Disorder: A Randomized Controlled Trial With 6-Month Follow-Up. *Frontiers in Psychiatry, 12*.

<https://www.frontiersin.org/article/10.3389/fpsy.2021.661807>

THESIS APPROVAL FORM

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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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