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Combining Non-traditional Therapeutic Competencies with Dance/Movement Therapy in Response to Client Reactivity: The Development of a Method

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Abstract

Individuals with reactive attachment disorder present as guarded towards therapeutic care and respond passively to treatment or become combative and aggressive. Previous body-based interventions for individuals with reactive attachment disorder included dangerous and unethical approaches that led to traumatization, distrust, and even death. Historical attachment therapies focused on making the client feel powerless and hopeless to accept care rather than practitioners adjusting to individualized client-centered care. A dance/movement therapy-informed method was developed to provide a nonthreatening therapeutic space to foster genuine participation for clients who present with reactivity towards treatment. The method was implemented over the course of seven weeks in weekly individual sessions with a female adolescent client who presented with reactivity towards therapeutic care. In response to this reactivity, sessions included activities that were familiar and non-threatening, including soccer, basketball, cornhole, volleyball, and going for walks. Body Attitude Coding Sheets and Laban Movement Analysis were used to record and assess the client's ability to coregulate, communicate, and create through her movement patterns and action efforts. Results included changes in the participant's pattern of action efforts as well as her use of coregulation, mirroring, and kinesthetic empathy.

Keywords: reactive attachment disorder, reactivity, dance/movement therapy, Laban movement analysis, residential education, adolescent females, coregulation, mirroring, kinesthetic empathy

Author Identity Statement: The author identifies as a heterosexual, White woman from Metro Atlanta of mixed European ancestry.

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Introduction

Abuse, neglect, and traumatic events impact youth and shape their connection to the outside world as well as their ability to obtain inner peace. If children experience continued exposure to interpersonal trauma when attempting to form attachments in infancy, they may develop unhealthy behavioral patterns, or more specifically, a mental health diagnosis such as reactive attachment disorder (RAD). RAD is classified as "a stressor-related disorder which can only be caused by social neglect during childhood (meaning a lack of adequate caregiving)" (American Psychiatric Association, 2013, p. 265). Individuals with this disorder usually present with fearfulness and hypervigilance; they exhibit poor social interactions with peers and aggression towards themselves and others (American Psychiatric Association, 2013). Due to repeated exposure to stress in childhood, these individuals exhibit hyperarousal in low-stress environments and act with impulsivity and reflexivity (Howard, 2013).

The correlating course of treatment for an individual with disrupted attachments would be attachment therapy; however, historic approaches to this treatment paradigm have been harmful and resulted in the death of multiple clients (Haney, 2021; Josefson, 2001). Attahcment practitioners utilized approaches of 'intrusive therapy' and 'holding techniques' which have been known to traumatize and injure clients. These techniques lacked evidential research and focused on the child's behaviors as isolated actions rather than a sum outcome of lived trauma (Haney, 2021). The effects of harm in historically implemented attachment therapies have received considerable attention and driven parents and clients away from attachment-focused therapy as a

whole. However, the need for curated and specialized therapeutic approaches for these clients remains and has left many parents with fewer safe, ethical, and effective options.

Although these past treatment methods engaged the body in a harmful manner, the use of engaging the body in treatment can strengthen the body-mind connection and form attunement, kinesthetic awareness, and self-regulation skills which can all be accomplished using dance/movement therapy (Dieterich-Hartwell, 2017). Dance/movement therapy is an evidenced-based practice that analyzes the nonverbal cues clients exhibit to inform therapists of underlying emotional states (Cruz, 2016, Dieterich-Hartwell, 2017). Including the body and movement in therapeutic sessions with traumatized or abused clients strengthens their body-mind connection, which has experienced disruptions in self-regulation, as well as perceiving the environment correctly (Dieterich-Hartwell, 2017).

The aim of this study is to fill the gap in research of body-based therapeutic interventions with traumatized clients who have a diagnosis of RAD. My method focused on the therapeutic engagement of an adolescent female residing in a residential level of care program who has multiple diagnoses, including RAD. Over the course of 9 weeks, I provided therapeutic interventions that promoted body engagement and analyzed my client's movement patterns utilizing Laban movement analysis, a dance/movement therapy assessment tool (Levy, 1992). I collected and organized my data using body attitude coding sheets designed to include the context of our sessions and cultural considerations. My analysis of these movement patterns strives to include the oppositional and defiant presentation I received from her when presenting the session space as therapeutic. My method includes the realistic reactions from reactive clients and how to curate an environment that relieves pressure from clients who cannot engage in

traditional therapeutic spaces. Results indicated that individualized treatment interventions and client-centered care improve a reactive client's ability to participate in body-based interventions.

Literature Review

This literature review will be divided into three sections, including the presentation of reactive attachment disorder, harmful effects of historical unethical attachment therapy interventions, and the potential benefits of dance/movement therapy as a non-traditional therapeutic approach.

Reactive Attachment Disorder

Relationships can give purpose; they define roles in communities while simultaneously fulfilling the desire for acceptance. Most theorists consider the infant-caregiver relationship as the first connection a human encounters. The infant relies on the caregiver for survival while the caregiver relies on the infant for successful gene replication. Atkinson (2019) acknowledged the dyadic nature of relationships and reliance of both parties on one another; this mutuality is what creates attachment. Attachment is relational, not individual, and is evident in behaviors and attunement towards one another. Bowlby (1969), one of the major attachment theorists, emphasized the importance of examining evolutionary adaptedness as context of relational behaviors. When disruption in a mutual relationship develops and occurs consistently, this poses a threat to a child, and disorganized attachment can develop. Cases of neglect and abuse can lead to disorganized attachment and impact the child's ability to create new attachments later in life (Atkinson, 2019).

Presentation and Behavioral Patterns

According to Atkinson (2019), how a child interacts with others reflects their level of comfort, trust, and potential for future relational engagement. Disorganized attachment in an

abused child can present as inhibited type or disinhibited type, which differ in presentation. Disinhibited type of attachment presents as indiscriminate sociability with no differing relational behaviors with caregivers, exhibited by excessive familiarity with strangers (Prior & Glaser, 2006). These children may appear anxious, overshare personal information with strangers, indiscriminately seek attention and comfort from everyone, and display inappropriate childish behaviors uncharacteristic of their age (Howard, 2013).

Inhibited type presents as resistance to creating an appropriate connection through either behaviors of hypervigilance and isolation, or with reactivity and contradictory responses (Prior & Glaser, 2006). Children with inhibited type of attachment are usually withdrawn, emotionally detached, unresponsive to comfort, and may push people away or get aggressive when people try to get close (Howard, 2013). Both presentations develop as a result of inconsistent relational attachment and over time, these types can develop into reactive attachment disorder (RAD) and disinhibited social engagement disorder (DSED) (American Psychiatric Association, 2013). This research will focus on inhibited type of attachment and reactive attachment disorder (RAD) by including experiences and observations from individual counseling sessions with an adolescent client who has this presentation and diagnosis.

Regulation and Trauma Responses

Developed from attachment-based theories is Schore's (2017) regulation theory. Regulation theory poses that an infant's capacity to regulate is based on their interactions with their caregiver, including, affect communication, attunement, and consistent coregulation (Schore, 2017) If an infant experiences acute pathogenic care, such as neglect or abuse, their capacity to emotionally self-regulate is diminished. Schore (2017) explained, "the disruption of attachment transactions leads to a transient regulatory failure and an impaired autonomic

homeostasis" (p. 390). Persistent exposure to early relational trauma can potentially damage areas of the brain responsible for regulation when experiencing stress (Vasquez, 2018).

The regions of the brain that control executive functioning, emotional regulation, and dissociation/interoceptive awareness are often underdeveloped in youth who experience abuse or neglect (Cross et al., 2017). These developmental deficits occur due to prolonged exposure to cortisol which increases hypervigilance and establishes a lower threshold for stress (Cross et al., 2017). Exposure to abuse and neglect in childhood leads to maladaptive and disorganized neural development (Howard, 2013). Examination of severely neglected children's neurological scans has shown smaller brains measured by mass as well as increased misguided activity towards the brain stem, referred to as the "survival" part of the brain, instead of utilizing the intended regions created for stress, like the cortex (Howard, 2013).

This impairment limits these children's capacity to problem solve or reason with their emotionally driven limbic system, making it difficult to calm feelings and plan their behavioral responses (Howard, 2013). Heightened senses of urgency and stress in the body increase these children's level of dysregulation, while lacking the tools to self-soothe or self-regulate (Cross et al., 2017). At this point in the child's life, behavioral responses are purely reflexive and emerge to protect the child in the most extreme circumstances (Howard, 2013). Environmental factors that would go unnoticed by neurotypical children, like facial expressions, loud voices, particular smells, or a physical proximity to others, can trigger these individuals into crisis (Howard, 2013).

History of Unethical Attachment Therapies

For individuals with any diagnosis, finding the correlating therapeutic intervention is necessary to treat the identified symptomatology. Specifically for individuals with RAD, the previous recommendation included attachment therapy, which addresses disrupted attachments,

reactivity to treatment, and a lack of engagement in the therapeutic process. However, attachment therapies of intrusive therapy, rebirthing, and holding techniques are all derived from *rage theory*, which is "a theoretical approach that is based on clinical observations rather than scientific findings" (Haney, 2021, p. 76). Rage theory is an outdated belief that 'catharses' could rid traumatized children of negative behaviors which is inconsistent with Bowlby's attachment theory and current developmental psychology theories (Haney, 2021). Rage theory's conceptualizations attribute the child's reactions to learned behaviors the child is choosing to engage in, rather than reflexive trauma responses due to disorganized neural pathways (Haney, 2021, Howard, 2013).

Intrusive therapies and holding techniques have little to no evidential backing and in some instances, have done more harm to clients than good. According to reports, there have been six recorded client deaths caused by untrained therapists using unethical holding techniques (Lawson et al., 2021). One 10-year-old client's death caused by rebirthing included her adoptive mother and two attachment therapists smothering her with blankets and pillows for 40 minutes, while pressing down on her (Haney, 2021, Lawson et al., 2021, Josefson, 2001). Intrusive therapy and holding techniques are meant to provoke rage and include physically restraining a client until they feel powerless and helpless enough to give in or make amends with the attachment therapist (Cline, 1992, Haney 2021). It is important to note that not all attachment therapies in the paradigm are unethical or lack evidential backing, but the specific techniques of intrusive therapy, holding techniques, compression therapy, and rebirthing will all be investigated further in this literature review to identify the harm that can be done without proper training, theoretical backing, and improper handling of body-based interventions.

Intrusive Therapy

The development of intrusive therapy began when attachment theorists like Cline (1992) observed clients' refusal to participate in treatment and became distraught with clients' reactionary behaviors. Adolescents and children would passively ignore therapists during session or use threatening language and violence when they were not ready to become vulnerable (Cline, 1992). Cline attempted to rationalize that waiting for children to identify when they are ready to participate was a disservice to the client and kept them "'trapped' by their more intact ego defense mechanisms" (p .79). This was when Cline developed intrusive therapy to force psychological engagement when a client would rather passively withdraw or actively obtain control over the session (Cline, 1992). Cline defined intrusive therapy:

> Intrusive therapy is the use, if necessary, of physical or verbal provocative techniques, (after obtaining informed consent) which bring on expressions and feelings of loss, pain, and/or rage, helplessness, and hopelessness in a setting and/or in a manner that encourages resolution of those feelings through genuine acceptance, love and understanding. After obtaining informed consent, and when offered by a therapeutic professional, the end result is bonding and attachment. (p. 63)

This method includes unethical techniques with no past studies to compare these children to control groups, no assessments have been completed by outside researchers other than the partitioners performing the techniques themselves, and there is no empirical data to support client improvement resulting from the actions taken (Moon, 2001).

Cline (1992) stated that resistant clients must feel powerless and helpless to experience true openness and connection with therapists. Throughout time, attachment therapists included additional ways of instigating clients including poking, prodding, tickling, licking, forced eye

contact, and even sitting on clients (Haney, 2021). Practitioners now know that holding techniques and physical restraints can retraumatize clients who have suffered from abuse and the result Cline identified as 'relief' is the reiteration of learned helplessness. Cline stated, "the only joy in such a session occurs when [the client] find[s] that on complete surrender of control, they are loved, accepted, and gratified" (p. 79). However, the clients are not finding 'love,' but rather experiencing the same abuse that brought them to therapy (Chaffin et.al., 2006).

Rebirthing

One widely reported instance of harm caused by attachment therapy includes the death of Candace Newmark, a 10-year-old adopted girl who died during an intervention called rebirthing. Rebirthing is a technique used by attachment practitioners where the client undergoes an imagined birth process, "the process deletes negative emotions left over from the past and creates a readiness to enter positive relationships" (Mercer, 2001, p. 106). These practitioners entrap the client in blankets and pillows to simulate a womb with the free end of the blanket twisted into a loose knot (Haney, 2021). The client is encouraged to wriggle free through the twisted end while practitioners simultaneously push down on the client to simulate uterine contractions (Josefson, 2001). In Candace Newmark's 70-minute session resulting in her death, she was wrapped tightly with her head covered and pushed down on with a combined weight of 304 kg (Josefson, 2001, Mercer, 2002). Video recording shows that Newmark asked the practitioners to stop repeatedly, but ultimately, she died from asphyxiation (Josefson, 2001, Mercer, 2002). The practitioners who caused the death of Newmark were criminally charged and imprisoned (Josefson, 2001). Immediately after these court rulings, Colorado signed into effect Candace's law which bans the use of active restraint in all psychotherapeutic treatment (Josefson, 2001). Additional video evidence shown in court revealed that, "this child [Newmark] was grabbed by the face during a

holding session, pinned under her mother during a session of compression therapy, and was licked by her adoptive mother during some sessions" (Haney, 2021, p. 76).

Untrained practitioners used rebirthing to "psychologically rebirth" clients to provide them with a new sense of self without any foundational backing in attachment theory (Haney, 2021, p. 76). Rebirthing and other coercive attachment techniques intend to make a client feel powerless; that their parents or guardians have complete and total control over their well-being (Chaffin et. al., 2006, Haney, 2021). Other attachment techniques include diapering older clients and nursing them with bottles and pacifiers to repress them to a younger development state where they can relive early trauma (Chaffin et. al., 2006). Attachment practitioners provoke catharsis and encourage a ventilation of anger from their clients; however, research has shown that encouraging physical expressions of anger in therapeutic interventions increases levels of anger and aggression in clients towards others outside of session (Chaffin et. al., 2006). These clients, who are told to cope with trauma through anger, exhibit a decreased ability to adapt to their environments effectively as well as a lack of control over their emotional responses (Chaffin et. al., 2006). The unethical use of attachment therapies has received attention from the International Working Group and the American Professional Society on the Abuse of Children (APSAC) who have identified these methods as unsafe and ineffective; these interventions resulted in multiple child deaths and lawsuits from the countries of Russia, Britain, and the Czech Republic (Chaffin et. al., 2006, Mercer, 2014).

Gap in Care for Individuals with RAD

In response to these tragedies, parents and guardians began to shift away from all attachment therapies and non-traditional therapeutic approaches to protect their children from coercive techniques. The harm from unethical practices impacted all types of attachment

therapies, including ethical and evidence-based techniques developed from attachment theory, cognitive behavioral conceptualization, and parent training (Haney, 2021). To fill this gap in treatment, psychotherapists researched the effects of talk-therapy and intergenerational psychoanalysis with these clients, which did show some positive outcomes (Colangeli, 2020). However, psychoanalytic approaches alone for clients with RAD would not account for differences in treatment accessibility, cultural competency, or individualization of treatment, the requirements that having a variety of scopes of practice satisfied. Due to the fear of repeating harm, a gap has formed in treatment options, meaning fewer therapists are engaging in any body-based interventions with clients to avoid misconceptions (Haney, 2021). Previously used unethical treatments forced the clients into physical interventions with goals to engage the body, attempt coregulation, and use metaphorical movement. Although these treatments did harm, their theme of encouraging the client to utilize their body as an instrument for treatment could benefit children with trauma and disrupted attachments if used correctly (Dieterich-Hartwell, 2017).

Dance/Movement Therapy

Dance/movement therapy (DMT) is an ethical and evidence-based treatment method that appropriately encourages clients to use their bodies in treatment to process trauma, coregulate, and creatively express themselves (Cruz, 2016, Dieterich-Hartwell, 2017). Multiple studies have analyzed the impact of DMT on traumatized populations and its ability to heal these clients who are experiencing intense trauma responses manifesting in their physical being. Meekums (1999) found in her treatment with women survivors of child sexual abuse that establishing safety in the session and the witness/being witnessed relationship were essential in changing their symptomology. Devereaux (2008) used DMT with a family who experienced domestic violence and assisted the family in finding new ways to self-regulate. Moore (2006) also worked with

victims of domestic violence and found that DMT helped clients notice sensations in their bodies and increased their level of emotional intelligence by naming the felt emotion. Mills and Daniluk (2002) researched the positive effects of DMT in clients' ability to stay present in their body when painful memories or flashbacks occurred instead of involuntarily dissociating. DMT researchers have committed to using ethical and noncoercive techniques that have shown positive results in clients with histories of abuse and disrupted attachments.

Many psychology theories and theorists set the foundation for DMT theory including Freud, Reich, Jung, Rogers, and many others. Freud acknowledged the importance between the body and emotions and identified a relationship between psychoanalytic thought and nonverbal communication (Levy, 1992). Creative expression from clients expands the understanding of their unconscious and psyche as well as provides additional outlets to communicate nonverbally. Reich introduced the idea that clients who are not able to communicate verbally hold emotions in like an 'armor,' which presents as muscular rigidity (Levy, 1992). This muscular armor was a point of focus for Reich in treatment: "Reich introduced the use of muscular manipulation to overcome armoring and thus facilitate the release of repressed psychological material" (Levy, 1992, p.7). Jung included in his theoretical approach, the importance of active imagination and the use of creative expression in treatment with clients (Levy, 1992). Carl Jung's approach directly supported DMT theorist, Mary Whitehouse, in her examination of client behaviors. Whitehouse utilized improvisational movement as a tool for clients to uncover the unconscious which transformed into authentic movement, a tool widely used by dance/movement therapists (Levy, 1992). The beginning of the humanistic movement truly gave DMT a platform to stand on and widened practice. Roger's humanistic approach motivated clients to aspire, create, and fulfill their potential rather than focus on diagnoses and weaknesses (Levy, 1992). The humanistic

movement also reframed the perspective of practitioners and increased accessibility to treatment for clients who may not benefit from traditional or talk therapy.

Laban Movement Analysis

Dance/movement therapists not only utilize movement as a medium for creative expression, but they also observe and evaluate client's movements to track client progress, signify potential changes, and identify cultural differences. Laban Movement Analysis (LMA) is an established clinical assessment tool in which dance movement therapists can record and analyze client's movements and emotional expression (Tsachor and Shafir, 2019). LMA is a system created to cite and explore an individual's movement patterns as an expressive medium to discover potential meaning in the client's conscious and unconscious, as well as to pass on cultural traditions and religious rituals (Levy, 1992). Laban's student, Irmgard Bartennieff, contributed to Laban's observation system by identifying the importance of movement pathway development throughout infancy and into childhood when assessing a client, which is why some researchers refer to this system as Laban/Bartenieff Movement System (LBMS) (Hackney & Weeks, 2002, Tsachor & Shafir, 2019). In a meta-analysis, Tsachor and Shafir (2019) collected past studies that utilized LMA and found, "LMA, and systems emerging from it, have a strong record of interobserver reliability when applied carefully by raters trained for research" (p. 2).

LMA includes various criteria such as drives, efforts, and shapes of observed movement (Levy, 1992). Drives and effort focus on how the client moves by identifying qualities based on space, weight, time, and flow (Levy, 1992). Shapes of movement identifies how a client interacts with their environment and own body, such as moving in pathways, in relation with body parts, and molding to interact with environmental factors, such as cradling an infant (Levy, 1992). Researchers who utilize LMA to record and analyze movements may utilize body attitude coding

sheets which include LMA specified drives, efforts, shapes, and some researcher specific criteria such as situational context of the movement and cultural context of the client (Tsachor and Shafir, 2019). My research will analyze my participant's movements through the system of LMA to identify patterns and proper identification of dysregulation so that individualized treatment can be implemented when needed.

Method

This section will identify the specific implementation and use of dance/movement therapy with an individual who is diagnosed with reactive attachment disorder. Additionally, this section will further explain the participant involved, the materials used, the structure of the method, and the way in which the participant's progress was tracked and organized.

Participants

This method was curated specifically to the individualized needs of one participant who is identified with the pseudonym "McKinley" throughout this paper. McKinley is an adolescent cisgender female student residing at residential educational level of care in the Northeastern United States. McKinley was raised in the Northeastern United States, is English speaking, able-bodied, and identifies as Caucasian. McKinley is diagnosed with reactive attachment disorder with additional comorbidities. As evidenced by her diagnosis and case history, McKinley experienced extensive trauma throughout her childhood which impacts the way in which she forms attachments with others. The residential program in which McKinley received treatment instilled a trauma-informed care model known as the Attachment, Regulation, and Competency (ARC) Framework. The ARC Framework focuses on interventions that model healthy relationship building, teach self-regulate skills, and enhance self-worth through identity building. McKinley and I met for supplemental individual therapy for approximately four months prior to

beginning the method. The additional four months of rapport building contributed positively to the researcher and McKinley's therapeutic relationship and most likely allowed for an authentic experience of working with a client with RAD.

Materials

The materials mentioned in this method include specific sports and arts equipment. The specific materials used with McKinley include markers, construction paper, a soccer ball, basketball, basketball hoop, volleyball, yoga ball, and cornhole equipment such as beanbags and boards with scoring holes. These materials were chosen due to McKinley's experience with sports and cultural identity which aligns with materials commonly seen in American culture.

Procedure

The implementation of this method included weekly individual therapeutic sessions with McKinley where the therapeutic activity of each session was curated based on the body efforts and actions observed in her session the week prior. Criteria that influenced the theme and direction of the method included observed effort qualities in movement, McKinley's ability to coregulate appropriately, and her engagement in goal-oriented movement. Effort qualities exhibited by McKinley indicated areas of her movement and body in which she holds tension, expresses emotion, and stores energy. In addition, McKinley's ability to coregulate was examined through feelings of countertransference while in session and levels of force felt through a ball used in therapeutic object play. The specific order of session activities was chosen to challenge McKinley's use of goal-oriented movement and influence her level of control and intentional movements when trying to achieve a goal in session.

Data Collection

Session data and observations were recorded using body attitude coding sheets, these were completed after each session using the vocabulary and theoretical framework of LMA. Each body attitude coding sheet includes the participant's name, date, and time of the session, the context of what happened before and during the session, a short mental status exam, a table including different areas of movement activation and efforts used in frequently performed actions, and post-session observations. Movement recorded included engagement or changes in McKinley's observed breath, kinesphere, Posture/Gesture, Spatial Stress, Active Body Parts, Held Body Parts, Bartenieff Fundamentals, and Laban Action Efforts.

Changes in McKinley's breath were recorded when they occurred in session, but when there was no change that was indicated by using "WNL" which translates to 'within normal limits.' The kinesphere observations recorded include how McKinley interacted with the world around her by identifying how often and with what intentions she left her personal space to connect with others and her environment. By observing McKinley's postures and gestures, the researcher analyzed her potential emotional expression and level of engagement, which she expressed nonverbally. Spatial stress observations include how McKinley utilized her space and the way she expressed energy or rest. Active Body Parts and Held Body Parts identifies specific parts of McKinley's body where she either held tension and expressed energy by moving or staying inactive. The Bartenieff Fundamentals identified in McKinley's movement refer to movement pathways developed throughout infancy and into childhood. These pathways emphasize a person's ability to navigate the entirety of their body and development milestones achieved (Hackney & Weeks, 2002). The final section of Participant Actions includes actions exhibited frequently by McKinley or actions that appeared to have larger meaning beyond the

surface. Each Participant Action has a correlating Laban Action Effort which identifies the quality McKinley's movement had and how it presented or felt to herself and others.

Results

This section will report the findings of each session and focus on actions made by McKinley as well as feelings of countertransference from my own perspective.

Session 1: Dance/Movement Therapy

The beginning of this method focused on the implementation of dance/movement therapy as a body-based intervention with McKinley. Session 1 took place in the recreation room and included tools of a speaker, to play music, and a safe open space; the plan was to engage McKinley in light stretching and some introductory dance/movement exercises. In the recreation room, there were additional materials that cannot be removed, such as an exercise bike and the basketball hoop. The session had a set goal to participate in minimal beginners' movement while also engaging in talk therapy, a treatment method that is familiar to McKinley.

When entering the session, McKinley saw the music speaker and immediately became reactive in her presentation. Without even being instructed to move, McKinley stated that she was not dancing. McKinley continued to present with reactivity as evidenced by her closed off body language and her verbal responses of "this is stupid" and "that's not fair," (see Appendix A). McKinley exhibited gestures of staring out the window away from the clinician with her arms crossed and leaning on the windowsill with her cheek rested on her hand. McKinley resorted to bargaining by asking to use half the session time with her preference of activity. I responded to McKinley's behaviors by setting the expectation that session will last the minimum of 30 minutes with no option to change the session activity. McKinley refused to participate for the entirety of session and sat away from me with no engagement. When finishing this session,

McKinley was reminded that sessions will require her engagement in processing emotions, feelings of dysregulation, and current happenings while in treatment. McKinley continued to present a flat affect and transitioned out of session, back to her bedroom.

Session 2: Expressive Arts Therapy

After assessing McKinley's reaction to DMT the week prior, I chose to use multi-modal tools from art and music therapy to prompt McKinley to participate in lyric analysis, another method McKinley is familiar with. Session 2 included tools of markers, construction paper, and a printout of lyrics to a predetermined song chosen by McKinley. The planned goal of Session 2 included utilizing lyric analysis to create artwork that resonated with McKinley. This session began with the set expectation to participate in some modality of expressive arts therapy.

When entering the session, McKinley responded with the same reactive presentation as the week prior. After hearing instructions, McKinley verbally responded with "this is boring" and refused to participate in the presented activity. McKinley exhibited gestures of sinking into her chair, contracting her chest with crossed arms, and staring at the ground, (see Appendix B). After some prompting, McKinley's artistic response included a drawing of a "lonely tree" saying "I'm bored." Similar to the previous session, I responded to McKinley's behaviors by setting the expectation that each session will last the minimum of 30 minutes with no option to change the session activity. In session 2, McKinley engaged in artistic prompts with reactivity by creating artwork that included television show references, sarcastic responses, and negative comments directed towards therapy, none of which correlated to the session's directive of lyric analysis. When finishing session, McKinley was given the same reminder as the previous week, that session will require her engagement. McKinley was not receptive to this and continued to exhibit closed-off body language when concluding session.

Session 3: Going for a Walk

Due to McKinley's reactivity in the first two sessions, the method evolved to accommodate the needs of McKinley and to promote authentic engagement in session. The focus of Session 3 needed a pairing of a familiar, non-threatening activity in combination with observed movement engagement, which resulted in session 3 becoming 'going for a walk.' McKinley's treatment program allows clients to take walks with staff through a nearby neighborhood past houses and a cycling trail. McKinley presented with a bright affect when told session would consist of a walk and continued to exhibit an energetic and enthusiastic presentation for the entirety of session. McKinley was physically active throughout session, consistently engaging with her environment by climbing snow mounds, throwing snowballs at street signs, kicking snow off the sidewalk, and challenging me to a race, (see Appendix C). Similar to sessions 1 and 2, a moment of reactivity occurred where McKinley pretended that she was running away, but stated "you know I would never actually do that" when returning.

Session 4: Soccer

Due to the positive engagement from McKinley in session from the prior week, this method continued to use nonthreatening, familiar activities in combination with movement engagement to promote participation from McKinley. While investigating McKinley's interests, it surfaced that she participated on the soccer team this year, which is how soccer became the designated activity. I prepared the materials for session prior to McKinley's arrival to disguise the session's planned activity and to pull attention away from my intentions. McKinley immersed herself into the activity when she believed that it was not premeditated. I set myself across the recreation room from McKinley on her sagittal plane, the front of my body lined up with the front her body and facing one another, with hopes of passing the ball to one another, a

common activity for coregulation. McKinley kicked the soccer ball with no intention of its placement or consideration to her level of force being used. The soccer ball hit the wall behind me, the basketball hoop, the windows, and even knocked my walkie talkie off the windowsill, (see Appendix D). Very rarely did I have the soccer ball passed towards me with a manageable or nonthreatening force.

Often, I redirected McKinley to lighten her force in order to create a rhythm for coregulation. McKinley would adjust her force briefly, but quickly resorted back to her forceful kicks. The intensity of these kicks was so powerful that they impacted more than the environment around her; they impacted McKinley herself. On one occasion, McKinley's shoe flew off when she kicked the soccer ball, and in another instance her legs swept out from underneath her, causing her to fall backwards onto the ground. McKinley was active for most of the session with one exception. McKinley became distracted by an ambulance across the street and watched while staring out the window. McKinley began to share an experience of running away from home a couple of years ago and returning home to find police cars outside of her home. After asking some questions for context, this moment of vulnerability did not last long and McKinley quickly resumed kicking the soccer ball towards every direction in the room.

Session 5: Basketball

Sessions 5 included a nonthreatening, familiar activity McKinley had engaged in prior to this session, basketball. Basketball focused on goal-oriented movements such as scoring a basket which encouraged McKinley to exhibit control and intention in her movements. During session 5, McKinley stayed in one spot for most of the session, directly in front of the hoop, shooting the basketball on her sagittal plane. McKinley would shoot the ball, then stand and wait for me to retrieve the ball and throw it back to her to repeat the cycle. Occasionally, I would shoot the

basketball as well. I prompted McKinley to throw the ball to me, imitating the way in which she would shoot a basket. In response, she threw the ball forcefully towards my chest carrying a more than necessary impact when passing the basketball. I gave McKinley feedback to pass the basketball with an arc-like pathway; this would need decreased force and use of the vertical plane instead of just the horizontal. With multiple tries, McKinley was able to engage in appropriate passes and exhibited a new effort quality of 'gliding' instead of her previous seen effort of 'punch,' (see Appendix E).

Session 6: Cornhole

For Session 6, the theme of utilizing nonthreatening familiar activities continued and the chosen activity used with McKinley was the game of cornhole. Cornhole included goal-oriented movement more precise than the previous session due a smaller goal hole and a heavier object used for scoring. Session 6 was also shorter in length than past sessions due to school vacation occurring that week. McKinley entered session with a euthymic and pleasant affect ready to compete in cornhole, but throughout session she became distracted and reminded this writer multiple times that she would like to join the art activity she signed up for which was starting soon. McKinley participated in session and exhibited control over her movements that had yet to be observed. McKinley exhibited the same arcing pathway provided to her through feedback during the previous session. Out of all her efforts observed, none of them contained a punch effort, which is the first time while engaging in movement she did not implement extreme and direct force. McKinley continued to use reactivity to relationally connect with this clinician as evidenced by when she kicked my thrown beanbags to prevent them from reaching the scoring board, (see Appendix F).

Session 7: Volleyball

In session 7, I continued to utilize the method of combining non-threatening familiar activities with movement engagement for therapeutic use. To prepare for session 7, I placed a standard volleyball as well as a large, inflated yoga ball in the recreation room to experiment with effort qualities and object relations this session. When McKinley entered the recreation room, she presented as neutral with a flat affect and began to exhibit reactivity similar to that of sessions 1 and 2. McKinley would not leave the doorway, held the doorknob, would "accidentally" fall out of the doorway, and stated that she wanted to return to her room, (see Appendix G). I identified that McKinley had not responded to session with this presentation for multiple weeks and asked why she was responding in this manner. McKinley said that she had a "bad day," and when asked if she wanted to discuss it, McKinley responded, "Nun-ya" which translates to "None of your business".

I attempted to engage McKinley in session by punting the volleyball on her sagittal plane, to which McKinley responded by kicking it back to me. I adjusted my approach and responded to her behaviors by nonverbally rolling the ball to her while she continued to kick it back to me. We then established an attuned rolling-kicking rhythm. I attempted to use this rhythm to pull McKinley away from the door by rolling the ball slightly away from her post, potentially forcing her to let go of the handle. McKinley would attempt to reach the ball, but refused to let go of the handle, sacrificing her opportunities to kick the ball in exchange to stay in place. After a couple of failed attempts to pull her out of the doorway, I adjusted my approach again. I brought the ball and changed my positioning to be closer to McKinley on her horizontal plane and hid behind a wall, tucked away on an adjacent corner just out of McKinley's eyeline. I stood and waited patiently with the ball, which let McKinley's curiosity get the better of her. McKinley leaned

forward just enough to peek around the corner and see me, to which I responded, “Don’t look!’ and shooed her back to her post.

I continued to wait some amount of time and sporadically kicked the ball in front of McKinley, surprising her with an unknown timing and release of the ball. McKinley ran out from her post and kicked the ball with intense force. I regained control of the ball and walked it back to my ‘hiding place’ and began another cycle of waiting, releasing, reacting, and retrieving. I looked at McKinley and stated we were “now playing a game called sneak attack.” McKinley moved away from the door and became fully engaged and participatory in this new activity, almost forgetting her previous presentation of being withdrawn and reactive.

As the game of sneak attack continued, I shifted my plane of focus while staying on McKinley’s horizontal plane by moving my facing to mirror McKinley’s. Sneak attack turned into parallel play of both McKinley and I taking turns kicking the ball against the same wall with matching force and undetermined intentions of the ball’s destination. McKinley would kick the ball, then I would retrieve it and kick it, then McKinley would retrieve it and kick it, and the cycle would repeat. McKinley continued to participate and became verbally engaged as evidenced by her comments on her ‘score,’ the number of times the ball returned to her possession after a large kick against the wall. We both continued the rhythm of individual kicking and retrieving until McKinley did something that she had never done before.

McKinley picked up the ball, walked forward, away from her kinesphere, and shifted her plane of focus to face me on my sagittal plane. McKinley adopted the same positionality and posture that I had exhibited when first starting the session. McKinley then rolled the ball to me and allowed me to kick it, reversing our roles in session to allow me to experience the same catharsis I allowed her to feel. I began to mirror McKinley’s behavior from when she was in the

position of ‘kicker’. I kicked the ball forcefully with no intentions of its destination. McKinley continued to roll the ball to me, the ball whipping by her while she smiled and laughed. It was in this moment that I could finally understand her physicality and emotions through countertransference. I felt safe and supported in that moment, knowing that someone was there for me and tending to my needs. I can only infer that this is what McKinley felt and why she felt the need to provide me the experience as well. For the remainder of the session, McKinley presented back on baseline with energy and participation through physical and verbal engagement. Session closed with McKinley in a good space, and she returned to her room with a calm and pleasant presentation.

Discussion

This section will dissect and analyze the observations seen throughout sessions and discuss McKinley’s progress in relation to the given method. Coregulation will examine McKinley’s ability to adjust or attune to her partner while engaging in regulating activity. Positionality will examine the use of space during session and the effects of the participant’s and researcher’s physical relation to one another by using play therapy’s parallel play. Role reversal will focus on DMT principles including mirroring, Dance/Movement theorist Marian Chace’s kinesthetic empathy, and Dance/Movement Theorist Mary Whitehouse’s emotionally driven “authentic movement” to analyze the intentions behind McKinley’s actions (Levy, 1992, p. 66).

Coregulation

Pallini et. al. (2018) created a meta-analysis of research to examine the correlation between a clients’ attachment style and their ability to self-regulate and found that clients with a lower level of emotional control had increased difficulty regulating effectively and independently. When beginning adjunct therapeutic sessions with McKinley, the major goal of

treatment focused on regulation, more specifically McKinley's ability to learn new self-regulation skills and perform coregulation appropriately with others. McKinley had difficulty utilizing coping skills in the milieu that had connotations of 'therapy.' McKinley would engage in art making until she was asked to relate it to emotions; McKinley would engage in sports until she was prompted to use the punching bag when angry. McKinley relied heavily on distraction-based coping skills like watching movies, talking to staff, and taking walks, but refused cognitive-based strategies like reality acceptance, challenging irrational thoughts, or decatastrophizing.

The objective of this method focused on providing a nonthreatening therapeutic space to foster genuine participation and analyze McKinley's ability to coregulate appropriately through her movements and action efforts. A major component of this method was the use of objects as mediums for connection during coregulation. Throughout these recorded sessions, McKinley's engagement with these objects stayed consistent until she received feedback of my feelings of discomfort through countertransference displayed in her ability to adjust her level of force when passing the basketball. In session 3, McKinley and I went on a walk where McKinley was observed throwing snowballs at street signs, kicking snow off the walls, and running a race. In the following session, McKinley participated in soccer, where she kicked the ball with great force to the point of becoming a danger to herself and the environment around her. All of these actions displayed the Laban action effort of "punch," a combination of direct space, heavy weight, quick time, and bound flow qualities in one action (Laban, 1971, Laban & Lawrence, 1974). Most of McKinley's actions in sessions where she was physically participatory included "punch" action efforts in movements that do not necessarily require punch effort to occur.

In session 5, McKinley and I participated in basketball where we passed the ball back and forth to one another. McKinley passed the basketball to me, and I finally physically experienced the great punch effort that I had been observing throughout sessions. From this moment, I identified my own experience aloud to McKinley for us to collaborate the coregulation process through kinesthetic empathy. McKinley was able to acknowledge my experience and adjust her actions to lessen the force. Through time and scaffolding, McKinley was able to change her action effort while passing from "punch" to "glide" as seen in Figure 5. She also modified her use of spatial stress by changing the ball's pathway from exclusively the sagittal plane to now including the vertical and sagittal plane, which resulted in an arcing pathway from the ball. These changes in McKinley's use of effort and space while coregulating exhibit her acknowledgment and attunement to her partner's needs, which are the foundational blocks of Marian Chace's kinesthetic empathy (Levy, 1992).

Positionality

The positionality between McKinley and myself throughout sessions contributed to the way in which power was communicated in our relationship, as well as trust and safety. Play therapy explains the importance of using different positions between the facilitator and client when interacting in session according to the developmental stages of clients (Bakeman & Brownlee, 1980). Parallel play is identified as the transitional position between *alone play* and *group play*; this is where the client is focusing on working independently while having accessibility to another human when needed (Bakeman & Brownlee, 1980).

Due to the nature of her diagnosis, McKinley's reactivity in relationships presents itself through power struggles, testing limits, and verbal deprecations of others. These behaviors can be seen concretely, like in session 1 and 2 where McKinley called session "stupid" and wrote

"I'm bored." Or they can be seen through jokes and ingenuine accidents, such as McKinley pretending to run away from this clinician, or McKinley whispering "help me" and intentionally falling out the recreation room doorway. Throughout most sessions, McKinley and I would begin on the same sagittal plane, facing one another and interacting with one another face to face. So often, our sessions would become stagnant or derailed when interacting in this positionality due to McKinley's refusal, engagement in inappropriate force, or reactive joking behaviors. In the face-to-face positionality, I interpreted that McKinley perceived me to be representative of a physical barrier to her independence or of her resistance to therapy.

Although sessions 1 and 7 ended differently, they started almost the exact same way. McKinley and I entered session and immediately came to a face-to-face positionality where she then became reactive in response and refused to participate. Throughout session 1, I stood my ground and maintained the face-to-face positionality in response to McKinley. She attempted to physically face away from me to avoid feelings of discomfort while I held this position. In session 7, I changed my response to McKinley's reactivity and found a creative way to adjust my position to decrease intimidation and increase curiosity and collaboration. We began the 'rolling-kicking' rhythm in the sagittal plane, and then slowly transitioned into a position of parallel play where McKinley and I were both on the horizontal plane facing the same direction. The parallel play position allowed us to focus on our own activity instead of focusing on one another. There was no one available to identify as a 'barrier' or a 'challenger' since no one was in front of us. This position also allowed McKinley to decide when she felt comfortable enough to rejoin the face-to face positionality by leaving the space open for invitation. Parallel play contributed well to client-centered care by allowing the participant and clinician to work together rather than against one another.

Role Reversal

In session 7, curating the therapeutic space included containing the participant by upholding boundaries and expectations. McKinley presented as reactive, but the expectations of the space did not change, only the method in which I attempted to engage McKinley changed. This session's drastic changes included 'rolling-kicking,' 'sneak attack,' and finally 'parallel play.' Although the approach to McKinley's presentation had to be modified, the level of safety ensured in the space and my therapeutic presentation to McKinley did not change. When evolving a session to ensure the participant feels secure and supported, it is often difficult to maintain the initial theme or intention of the session. However, in this case, McKinley responded to this evolution in an unexpected and uncharacteristic manner.

Dance/Movement theorist Marian Chace often mirrored her clients' movements during therapeutic sessions as a way for her clients to see their attempts of communicating with the group (Levy, 1992). The use of mirroring one another in the space transformed from 'empathic reflection' to 'kinesthetic empathy' which is a major component of attunement between individuals (Levy, 1992). Completely unprompted, McKinley demonstrated role reversal during a session where I was catering to her needs to allow me to experience her perspective. After subconsciously examining my posture and gestures, McKinley filled my previous spot and began to roll the ball towards me while mirroring my effort qualities. McKinley reflected my same safety standards and presentation by using safe language, posture, and maintaining expectations. McKinley's attempt at recreating our previous 'rolling-kicking' in a role reversal solidified her feelings of safety and enjoyment in the exercise. McKinley may have felt as though the activity was cathartic enough to put aside her own benefit during session so I could experience catharsis

too. McKinley demonstrated kinesthetic empathy by setting aside her own advancements and physical pleasures in order to share the experience with others.

Mary Whitehouse's dance/movement therapy theory of authentic movement states that some movements are emotionally driven and occur with a relinquish of control (Levy, 1992). Whitehouse identified that there are "invisible movements" which lack emotional backing, and authentic movement which is driven by the "Self" and is a surrender with no explanation, just a need to try (Levy, 1992, p. 75). McKinley willingly embodied the position I modeled which is one she previously resented and struggled accepting. McKinley continuously displayed emotional reactions towards my role as the facilitator physically with her body language and verbally through statement of "this is stupid" and "I'm bored". Although McKinley struggled to become vulnerable or even accept the containment of this role, she subconsciously noted the posture, gestures, and positionality of the role to eventually step into it. The internal struggle of wanting to fight with this model while also becoming vulnerable enough to embody this model demonstrates the polarities of presentation and progress in treatment with individuals with attachment disorders.

There were several notable limitations when conducting this method that impact the method's results and potential future implementation of this method. This method only had one participant which was the foundation of this process while also being a potential hinderance to result interpretation. McKinley's results from this method cannot accurately represent the reactions of other clients with her same presentation. Another limitation to the study includes the impact of human error when performing movement analysis. McKinley's movements were never videotaped, and major movement patterns were recorded after session ended. Some detailed and nuanced movements could have been missed due to the inability to have concrete visual

recordings of sessions. I received assistance from my thesis consultant, a trained Board-Certified Dance/Movement Therapist, to conclude realistic and accurate interpretations as results. A final limitation of this study includes the historical biases of the assessment system used in this method. LMA was created by Rudolf Laban, a German choreographer who sympathized with National Socialist principles such as Social Darwinism and "racial hygiene" and acted on these principles where he held leadership roles (Dörr, 2003, p. 22). The racial and ethnic biases of Laban must be considered when using his movement analysis system to accurately capture the meaning or intention behind the movement patterns of participants who are not of European dissent.

The impacts of unethical and dangerous historically used attachment therapies cannot be undone; however, how we shape the evolution of attachment therapies can benefit both clients and providers in the future. McKinley is one of countless underserved clients who deserve individualized care that simultaneously challenges the client while empowering them. Diagnoses that include reactive symptomology are often stigmatized which can lead to improper or wrongful treatment. By utilizing creative modalities and examining the individual's identity, ethical and effective care can occur through collaboration and lead to progress. Although this DMT-informed approach appeared nontherapeutic at times, the progress and change in a client can be seen through the smallest of movements and subconscious actions as assessed through a DMT framework. Treatment should include high and modulated responsivity to a client's reactivity instead of fighting it to create a safe therapeutic space and begin breaking down walls.

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Appendix A

Thesis Specific - Body Attitude Coding Sheet from 1/20/2022

Participant: McKinley **Date: 1/20/2022 Time: 3:45pm**

Context: McKinley transitioned into session in a good space. Clinician encouraged McKinley to choose music and join her in the space for dance and movement therapy. McKinley refused to join clinician and sat away from clinician on the exercise bike and window. Clinician gave McKinley time and space to become comfortable, but McKinley 's demeanor and choice to not participate did not change. McKinley refused to join clinician and when asked why, she replied "because it's stupid." McKinley pushed limits with clinician by standing next to the door and whispering out the door "someone help me."

Pre-Session Observations:
Presentation: Upon approach, McKinley presented as euthymic and energetic with a bright affect. With time, McKinley's affect evolved to flat with a guarded presentation.
Behavior: McKinley was uncooperative with clinician and would not communicate her feelings past the phrase, "This is stupid."
Thought Process: McKinley exhibited coherent and organized thought processes.
Orientation: McKinley was oriented to person, place, time, and event.
Safety Concerns: McKinley was not on a safety precautions status during time of session.

Session Observations:

Body	Notes
Breath	**WNL**
Kinesphere	
Far Reach	Not observed
Near Reach	**Sat on exercise bike and held handles**
Medium Reach	Not observed
Posture/Gesture	
Gesture	**Pretended to call out from the door**
Posture	**Sitting in contemplation, resting arms and head on windowsill, watching clinician**
P/G Merger	Not observed
Spatial Stress	
Vertical	**Sat on exercise bike**

Horizontal	Not observed
Sagittal	Not observed
Active/Held	
Body Parts Held	**Entire body was held in postures for most of the session**
Body Parts Active	**Legs were cycling momentarily when messing with bike**
Fundamentals	
Head/Tail	Not observed
Heel/Coccyx	**Connection when cycling**
Scapula/Arm	**Connection when holding handles**
Thigh/Pelvis	**Connection when cycling**
Diagonal (upper-lower)	Not observed
Body Half	Not observed
Participant Actions	**Laban Effort Analysis**
Sitting on exercise bike	**(Direct, Heavy, Sustained, Bound = Press)**
Cycling	**(Direct, Light, Sustained, Free = Glide)**
Calling out for help by the door	**(Indirect, Light, Sustained, Free = Float)**

Post- Session Observations:

Clinician kept expectation that they would meet for at least 20 minutes and iterated to McKinley that session will include more challenging prompts and mediums the rest of the semester. McKinley and clinician concluded session and McKinley transitioned out of session in a neutral space.

Appendix B

Thesis Specific - Body Attitude Coding Sheet from 1/24/2022

Participant: McKinley Date: 1/24/2022 Time: 4:00pm

Context: Clinician provided resources of construction paper, markers, glue, and scissors for McKinley to engage in art making. Clinician curated the session space with specific chair and desk for McKinley to sit in. McKinley entered the session space and immediately had a negative response to the art materials. McKinley stated that she did not want to partake in the activity or discuss her feelings. McKinley refused to sit in chair designated for her but with time and encouragement was able to sit in clinician provided space. Clinician reminded McKinley of a previous lyric analysis activity McKinley previously engaged in and provided the prompt of creating her favorite line of the song with art. McKinley pushed back against clinician's prompts and stated multiple times that she did not want to engage in "therapy" because she "does not talk about her feelings." McKinley eventually used markers and paper to write "boaring" and "bob's burgers" on the paper as well as drew a "lonely tree" that had a speech bubble of the tree saying, "I'm bored."

Pre-Session Observations:

Presentation: McKinley presented as euthymic and energetic with a bright affect.
Behavior: McKinley was uncooperative with clinician and required redirection and support in participating in activity. McKinley engaged in bargaining with clinician in order to shorten session time focused on emotional processing.
Thought Process: McKinley appeared coherent with organized thought processes.
Orientation: McKinley was oriented to person, pace, times, and event during time of session.
Safety Concerns: McKinley was not on a safety precautions status during time of session.

Session Observations:

Body	**Notes**
Breath	**WNL, expressed boredom with sighs**
Kinesphere	
Far Reach	Not observed
Near Reach	**Writing/drawing on paper**
Medium Reach	**Grabbing markers from bin and across desk, kicking legs under desk**
Posture/Gesture	
Gesture	**Crossed arms into body**

Posture	**Sunk into chair, contracted chest while staring at the ground, tucked legs into chest and held shins while sitting**
P/G Merger	**Crossed arms while sinking into chair**
Spatial Stress	
Vertical	**Standing in the space and refusing to down into a chair, used downward stress while sinking into chair**
Horizontal	**Grabbed markers from the sides of herself, stretch legs to the side**
Sagittal	**Lean forward over desk to draw/write, kicked legs under herself in her chair**
Active/Held	
Body Parts Held	**Chest would be held in contracted position for long periods of time**
Body Parts Active	**Kicking legs under desk, using legs to stop clinician from moving chairs**
Fundamentals	
Head/Tail	**Connection when sinking into chair**
Heel/Coccyx	**Connection when kicking legs under desk**
Scapula/Arm	**Connection when drawing/writing, connection when grabbing markers**
Thigh/Pelvis	**Connection when leaning forward over desk, tucked legs into chest and held shins while sitting**
Diagonal (upper-lower)	Not observed
Body Half	Not observed
Participant Actions	**Laban Effort Analysis**
Sinking into chair	**(Direct, Heavy, Sustained, Bound=Press)**
Grabbing markers	**(Direct, Light, Quick, Bound=Dab)**
Drawing/writing	**(Direct, Light, Sustained, Free= Glide)**
Stopping chair movements with leg	**(Direct, Heavy, Quick, Bound=Punch)**

Post- Session Observations:

When concluding session, clinician stated to McKinley that session time will include therapeutic aspects and participation will be expected of her. McKinley became reactive and visibly angry. McKinley stated that session time surrounding therapy and discussing emotions is “not fair.” Clinician and McKinley conversed regarding what future sessions will consist of and finished session. Clinician guided McKinley back to her room where she threw herself onto her bed faced down, silently, and hugged her pillow.

Appendix C

Thesis Specific - Body Attitude Coding Sheet from 2/3/2022

Participant: McKinley Date: 2/3/2022 Time: 12:30pm

Context: McKinley was pulled from class to meet for individual adjunct therapy session with clinician. Snow is on the ground outside in piles and there is a light mist of rain. Clinician and McKinley previously discussed taking a walk during session time as to which X's response was positive. McKinley is in high spirits due to being enrolled in a gymnastics class and reconnecting with an old teacher.

Pre-Session Observations:
Presentation: McKinley presented as energetic with a bright affect.
Behavior: McKinley attempted to test limits with clinician but overall was cooperative.
Thought Process: McKinley appeared organized with some distractibility that was easily redirectable.
Orientation: McKinley was oriented to person, place, time, and event.
Safety Concerns: McKinley was not place on a safety precautions status at the time of session.

Session Observations:

Body	**Notes**
Breath	**WNL, Faster and heavier after racing**
Kinesphere	
Far Reach	**Throwing snowballs at signs, kicking snow walls, Searched for an owl in the trees**
Near Reach	**Making snowballs with hands**
Medium Reach	**Kicking stick along walk**
Posture/Gesture	
Gesture	**Wiped face back and forth x2 (client-identified tic)**
Posture	Not observed
P/G Merger	Not observed
Spatial Stress	
Vertical	**Standing straight while walking, climbed to the top of a snowbank, bent down to make snowballs**
Horizontal	Not observed
Sagittal	**Walking, Running, Throwing snowballs,**

Active/Held	
Body Parts Held	Not observed
Body Parts Active	**Legs while kicking, Arms while throwing**
Fundamentals	
Head/Tail	Not observed
Heel/Coccyx	**Connection when running while racing clinician**
Scapula/Arm	**Connection when throwing snowballs**
Thigh/Pelvis	**Connection when client climbed to the top of a steep snowbank**
Diagonal (upper-lower)	**Connection when kicking snow on left side of her body away with right leg**
Body Half	Not observed
Participant Actions	**Laban Effort Analysis**
Throwing snowballs	**(Direct, Heavy, Quick, Bound=Punch)**
Running while racing clinician	**(Direct, Heavy, Quick, Bound=Punch)**
Climbed to the top of a steep snowbank	**(Direct, Heavy, Slow, Bound=Press)**
Wiped face back and forth x2 (client-identified tic)	**(Indirect, Light, Quick, Free=Flick)**
Kicked snow off the walls	**(Direct, Heavy, Quick, Bound=Punch)**
Searched for an owl in the trees	**(Indirect, Sustained, Light, Free=Float)**
Making snowballs with hands	**(Direct, Quick, Heavy, Bound=Punch)**
Kicking stick along walk	**(Direct, Quick, Light, Bound=Dab)**

Post- Session Observations:

When concluding the walk, McKinley ran a little ways away from clinician, joking that she would run away. McKinley then turned around and walked back towards clinician stating, “you know I would never actually do that.” McKinley walked back into residence with clinician and immediately began to walk swiftly away from clinician towards two employees. McKinley attempted to look over employees’ shoulders to read a note from another student. McKinley was redirected to return to class. McKinley appeared cheerful exhibited by her laughter and went to the school hallway to change her snow boots. McKinley returned to class with no issues.

Appendix D

Thesis Specific - Body Attitude Coding Sheet from 2/10/2022

Participant: McKinley Date: 2/10/2022 Time: 3:00pm

Context: Clinician took a soccer ball from the basement closet and put it in the rec room. Clinician walked up to milieu floor to pull McKinley for session. Staff reported that McKinley had just been kicked out of class for cursing at the teacher. McKinley received processing work as well as two repairs, one apology for the teacher and another to the teacher's assistant. Staff reported McKinley had a poor reaction to processing work and sat on the second shelf in her closet in retaliation. McKinley was writing her processing work upon approach and appeared calm. Clinician asked McKinley if she could meet for session now, to which McKinley agreed to. Clinician brought McKinley to the rec room where McKinley immediately sat on the exercise bike. Clinician began kicking a soccer ball to which McKinley said, "are we playing soccer?" Clinician replied, "no, I think someone left this here." McKinley immediately stood up and began kicking soccer ball with clinician.

Pre-Session Observations:
Presentation: McKinley presented as euthymic with a calm affect.
Behavior: McKinley was cooperative and communicative with clinician.
Thought Process: McKinley appeared organized with some distractibility that was easily redirectable.
Orientation: McKinley was oriented to person, place, time, and event.
Safety Concerns: Approximately one hour before session, McKinley was kicked out of class due to cursing at a teacher. McKinley received processing work and was assigned two repairs to the teacher and staff involved.

Session Observations:

Body	Notes
Breath	**WNL, Faster and heavier after kicking soccer ball and running**
Kinesphere	
Far Reach	**Kicking soccer ball at gym walls and clinician, kicked ball so hard client's legs flew out from underneath her, kicked ball so hard client's shoe flew off**
Near Reach	**Picking up soccer ball**
Medium Reach	**Trying to grab soccer ball from clinician's hands**
Posture/Gesture	
Gesture	**Pointed towards ambulance across the street**
Posture	**Standing upright and engaged**

P/G Merger	Not observed
Spatial Stress	
Vertical	**Juggling soccer ball with feet, kicking ball to the ceiling**
Horizontal	Not observed
Sagittal	**Kicking soccer ball against gym walls, running**
Active/Held	
Body Parts Held	Not observed
Body Parts Active	**Legs while kicking, arms while running, head while looking for clinician**
Fundamentals	
Head/Tail	Not observed
Heel/Coccyx	**Connection while running, connection while pulling back before a kick**
Scapula/Arm	**Connection when reaching to grab ball from clinician's hands**
Thigh/Pelvis	**Connection while juggling and kicking**
Diagonal (upper-lower)	**Connection across the body when kicking soccer ball**
Body Half	Not observed
Participant Actions	**Laban Effort Analysis**
Kicking soccer ball at gym walls and clinician	**(Direct, Heavy, Quick, Bound=Punch)**
Kicked ball so hard client's legs flew out from underneath her	**(Direct, Heavy, Quick, Bound=Punch)**
Kicked ball so hard client's shoe flew off	**(Direct, Heavy, Quick, Bound=Punch)**
Trying to grab soccer ball from clinician's hands	**(Direct, Light, Quick, Free=Dab)**
Running	**(Indirect, Quick, Light, Free=Flick)**

Post- Session Observations:

Clinician and McKinley reviewed tasks for McKinley to focus on for the rest of the night. McKinley reported wanting to finish processing work as well as repairs. McKinley also had new competency of gymnastics class out in the community for the first time that evening. McKinley reported feeling excited to be attending this class and was looking forward to it.

Appendix E

Thesis Specific - Body Attitude Coding Sheet from 2/14/2022

Participant: McKinley Date: 2/14/2022 Time: 4:00

Context: Prior to pulling McKinley, this writer placed a basketball from storage in the driveway near the basketball hoop for session**.** McKinley was pulled from her room to meet with clinician for individual adjunct session. McKinley was cooperative and appeared excited to meet with clinician. McKinley was brought from her room down to the basketball hoop. McKinley questioned what we were doing; this writer grabbed the basketball and began to shoot at the basket. McKinley readily joined in. McKinley stood in one spot and repeated waited for the clinician to pass the ball back to her to shoot again. McKinley was prompted by clinician to try different spots to challenge herself to which she accepted these recommendations. Clinician directed McKinley to pass the basketball to each other. McKinley threw the basketball with force exhibited a punch effort. Clinician redirected McKinley to toss the ball with an arcing motion as if throwing it into the hoop. McKinley accepted recommendation and slowly began to ease her level of force and change into a glide effort.

Pre-Session Observations:
Presentation: McKinley presented as energetic with a bright affect.
Behavior: McKinley attempted to test limits with clinician but overall was cooperative.
Thought Process: McKinley appeared organized with some distractibility that was easily redirectable.
Orientation: McKinley was oriented to person, place, time, and event.
Safety Concerns: McKinley was not currently placed on a safety precautions status at the time of session

Session Observations:

Body	**Notes**
Breath	**WNL**
Kinesphere	
Far Reach	**Shooting the basketball into the basket, reaching for basketball from clinician, throwing basketball back and forth with clinician**
Near Reach	**Passing the basketball in between her hands**
Medium Reach	**Dribbling basketball, 'defending' against imaginary players**
Posture/Gesture	
Gesture	Not observed

Posture	**Standing straight up, confident with shoulders back while shooting basketball**
P/G Merger	**Bent over with arms out to her sides 'defending' an imaginary player**
Spatial Stress	
Vertical	**Drippling the basketball, throwing the basketball between herself and clinician, shooting a basketball**
Horizontal	**'Defending' against imaginary players**
Sagittal	**Shooting the basketball, running to switch places**
Active/Held	
Body Parts Held	Not observed
Body Parts Active	**Arms while shooting basketball, legs when switching positions, feet when shooting (rolling up to the balls of her feet)**
Fundamentals	
Head/Tail	Not observed
Heel/Coccyx	**Connection when running**
Scapula/Arm	**Connection when shooting basketball**
Thigh/Pelvis	**Connection when switching positions**
Diagonal (upper-lower)	Not observed
Body Half	**Connection when 'defending' against imaginary players**
Participant Actions	**Laban Effort Analysis**
Tossing basketball to clinician before redirection	**(Direct, Heavy, Quick, Bound=Punch)**
Tossing basketball to clinician after redirection	**(Direct, Light, Sustained, Free=Glide)**
Trying to grab basketball from clinician's hands	**(Direct, Light, Quick, Free=Dab)**
Running	**(Indirect, Quick, Light, Free=Flick)**

Post- Session Observations:

McKinley was prompted to make a last shot. Clinician and McKinley readily wrapped up session to which McKinley was cooperative and stated she was ready to finish. Clinician and McKinley walked back up to the milieu where she went back into her room with no issues.

Appendix F

Thesis Specific - Body Attitude Coding Sheet From 2/24/2022

Participant: McKinley Date: 2/24/22 Time: 1:00pm

Context: McKinley is currently on school vacation holiday. The structure of McKinley's daily routines has shifted including no school this week, no therapeutic groups, and no individual sessions. Clinician and McKinley met for supplemental counseling this week to continue the implementation of this method. Clinician brought McKinley to the front yard where cornhole was set up for a game. McKinley engaged in activity, halfway through she became anxious that she would not be able to join art for her next activity. Clinician and McKinley only met for 20 minutes to allow McKinley to join next activity.

Pre-Session Observations:
Presentation: McKinley presented as euthymic with a pleasant affect.
Behavior: McKinley was cooperative and communicative with clinician.
Thought Process: McKinley appeared organized with some distractibility that was easily redirectable.
Orientation: McKinley was oriented to person, place, time, and event.
Safety Concerns: McKinley was not placed on a safety precautions status at the time of session.

Session Observations:

Body	Notes
Breath	**WNL**
Kinesphere	
Far Reach	**Throwing beanbags onto board**
Near Reach	**Switching beanbags between hands**
Medium Reach	**Picking up beanbags that were thrown**
Posture/Gesture	
Gesture	**Wiped face back and forth x2 (client-identified tic)**
Posture	**Listening to students in next room**
P/G Merger	Not observed
Spatial Stress	
Vertical	**Arcing the beanbag, bending down to pick up bean bags**
Horizontal	Not observed

Sagittal	**Throwing beanbag at opponent's board, walking to opponent's board**
Active/Held	
Body Parts Held	Not observed
Body Parts Active	**Arms while throwing,**
Fundamentals	
Head/Tail	**Connection when bending over**
Heel/Coccyx	Not observed
Scapula/Arm	**Connection while throwing**
Thigh/Pelvis	**Connection while throwing**
Diagonal (upper-lower)	**Connection while throwing**
Body Half	Not observed
Participant Actions	**Laban Effort Analysis**
Throwing beanbags	**(Direct, Light, Sustained, Free=Glide)**
Walking back and forth between boards	**(Direct, Heavy, Sustained, Bound=Press)**
Kicking clinician's bags	**(Direct, Light, Quick, Bound=Dab)**
Wiped face back and forth x2 (client-identified tic)	**(Indirect, Light, Quick, Free=Flick)**

Post- Session Observations:

McKinley and clinician agreed that McKinley had won their game of cornhole. McKinley appeared proud of her accomplishment and left session in a good space. McKinley was brought back to the supervisor to join art activity but was not included in the activity due to being pulled for treatment. McKinley appeared disappointed but was encouraged to join the second round of art activities occurring later in the day.

Appendix G

Thesis Specific - Body Attitude Coding Sheet From 3/3/2022

Participant: McKinley Date: 3/3/2022 Time: 3:00pm

Context: Reporting's showed that McKinley had a bad day and received feedback from staff that she had been knowingly pushing limits and testing low-level expectations. McKinley did not receive this news well and put her hood around her face in response to hearing this news. Before meeting with McKinley, this writer put a volleyball and large yoga ball into the rec room where session was planned to occur. Clinician pulled McKinley from her room to meet for individual adjunct therapy session. Immediately upon entering the rec room, McKinley became reactive and asked to go back to her room. McKinley exhibited exit-seeking behaviors including leaning against the door, holding the door handle, and "accidentally" opening the door and falling out.

Clinician identified the behaviors McKinley was exhibiting and identified that she has not presented this way in session in four weeks. McKinley reported she had a bad day. When this writer asked what happened McKinley responded, "Nun-ya." McKinley was withdrawn and refused to leave the door and join in a volleyball activity. Clinician bargained with client to go sledding she participates to which McKinley stated would only be fair if the incentive time was as long as the session time.

Clinician began to set the volleyball to McKinley, in response, McKinley would kick the soccer ball with much force. Clinician then adjusted to roll the volleyball to McKinley and allowed her to continue kicking the ball in this nature, still not leaving the doorway. Clinician and McKinley participated in what will be referred to as 'rolling-kicking.'

Clinician then took the ball and hid behind a wall close to where McKinley was planted. This writer kept the ball hidden behind the wall with her for numerous seconds. McKinley stepped away from the door out of curiosity to which this writer responded, "don't look!" and signaled her to return to the door. Clinician then kicked the ball in front of McKinley unexpectantly and McKinley kicked it with a quick reaction time. Clinician stated that they were now playing a game called "sneak attack." This interaction continued for some time and encouraged McKinley to step away from the door and return to this spot at her own discretion.

Clinician then began to face the same direction as McKinley and participate in kicking the volleyball with much force against the walls. Clinician and McKinley were on the same horizontal plane and interacted in parallel play. Clinician and McKinley took turns kicking the ball as hard as they could with no regard to where it would go. With no prompting, McKinley then stepped away from the door into the middle of the room and began rolling the volleyball to this writer to recreate the earlier partner activity of rolling-kicking. McKinley would retrieve the ball, roll it to this writer, and allow her to kick it will much force.

Soon after this last partnering, McKinley presented with much more energy and was ready and willing to participate in session. McKinley began to roll on the yoga ball in the room, throw the yoga ball back and forth, as well as, hit the yoga ball with the top of her head.

Pre-Session Observations:
Presentation: McKinley presented as neutral with a flat affect.
Behavior: McKinley was uncooperative with clinician and attempted to push boundaries throughout session.
Thought Process: McKinley appeared organized with some distractibility that required redirection.
Orientation: McKinley was oriented to person, place, time, and event.
Safety Concerns: McKinley was not placed on a safety precautions status at the time of session

Session Observations:

Body	Notes
Breath	**WNL**
Kinesphere	
Far Reach	**Falling out the door but pushing her arm against it to swing open, kicking the ball, rolling the ball to the clinician, throwing the yoga ball back and forth**
Near Reach	**Holding the doorknob**
Medium Reach	**Picking the ball off the ground**
Posture/Gesture	
Gesture	**Kicking the ball, Rolling the ball to clinician**
Posture	**Leaning backwards against the door, standing ready to kick**
P/G Merger	**Leaning past the wall to see what clinician was doing**
Spatial Stress	
Vertical	**Hitting the yoga ball up into the air, hitting the yoga ball with her head**
Horizontal	Not observed
Sagittal	**Kicking the ball against the walls**
Active/Held	
Body Parts Held	**Was still at the beginning of session**
Body Parts Active	**Legs when kicking, arms when throwing, arms when rolling, arms when hitting**
Fundamentals	
Head/Tail	**Connected when leaning backwards against the door**

Heel/Coccyx	**Connected when kicking**
Scapula/Arm	**Connected when throwing, hitting, and rolling**
Thigh/Pelvis	**Connected when kicking, connected when moving to the floor and rolling on yoga ball**
Diagonal (upper-lower)	**Connection when rolling ball to clinician**
Body Half	Not observed
Participant Actions	**Laban Effort Analysis**
Kicking soccer ball at gym walls and clinician	**(Direct, Heavy, Quick, Bound=Punch)**
Leaning forward to see what clinician was doing	**(Direct, Light, Sustained, Free=Glide)**
Kicking soccer ball with clinician	**(Direct, Heavy, Quick, Bound=Punch)**
Rolling soccer ball to clinician	**(Direct, Light, Quick, Free=Dab)**
Rolling on top of yoga ball	**(Indirect, Quick, Heavy, Bound=Slash)**
Hitting yoga ball back and forth with clinician	**(Direct, Heavy, Quick, Bound=Punch)**
Hitting yoga ball with head	**(Direct, Heavy, Quick, Bound=Punch)**

Post- Session Observations:

After approximately 30 minutes of session time, clinician and McKinley ended session and moved to the backyard where McKinley participated in sledding. McKinley went sledding down a hill multiple times and appeared to be enjoying the activity. Clinician brought McKinley back to her room where she appeared to be in a good space.

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: Nicole Koontz

Type of Project: Thesis

Title: Combining Non-traditional Therapeutic Competencies with Dance/Movement Therapy in Response to Client Reactivity, The Development of a Method

Date of Graduation: May 21st, 2022
In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Lee Ann Thill, PhD, LPC, ATR-BC