Healing the body: dance/movement therapists' approach to working with sexual trauma

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Abstract

Sexual abuse defined as any sort of non-consensual sexual contact is a widespread phenomenon. It is an experience of pervasive trauma that affects aspects of a person's emotional, physical and behavioral functioning. The aim of this research paper is to uncover how dance/movement therapy as a therapeutic modality can support the processing and integration of sexual trauma at a psychological and physiological level. Neuroscience and its understanding of the memory systems provided a rationale for the design of this study. A qualitative interview methodology was used: three somatically based clinicians were interviewed. Data analysis resulted in a conceptualization of sexual trauma and of the goals of treatment from a somatic perspective, four principles of somatic approach, fifteen themes of therapeutic material, and nine interventions to process trauma and further therapeutic growth. The underlying hypothesis of this research is that DMT, as a Somatic Psychology modality and with a neuroscientific correlate, is an optimal approach for working with sexual trauma.

Key words: dance/movement therapy, sexual trauma, neuroscience, implicit memory

Sexual abuse defined as any sort of non-consensual sexual contact is a widespread phenomenon in the world. Statistics calculating the prevalence of sexual abuse indicate that 7.9% of men and 19.7% of women worldwide suffer some form of sexual abuse prior to the age of eighteen (Pereda et al., 2009). According to data from the Centers for Disease Control and Prevention, a nationally representative survey of adults in the United States showed that 18.3% of women and 1.4% of men reported experiencing rape at some time in their lives, and approximately 1 in 20 men and women experienced sexual abuse other than rape in the 12 months prior to the survey (Black et al., 2011). Additionally, studies reveal that approximately 50% of transgender people in the United States experience sexual violence at some point in their lifetime (Stotzer, 2009).

In this paper, the term sexual trauma is utilized to signify an emotional response of significant distress caused by one or more instances of unwanted sexual contact. The aim of this research paper is to uncover and explore how dance/movement therapy as a therapeutic modality can support the processing and integration of sexual trauma at a psychological and physiological level, and support the healthy development of individuals who have experienced sexual trauma. Dance/movement therapy is a form of psychotherapy rooted in the premise that mind and body are interconnected, that the body reflects inner emotional states, and that changes in movement behavior can lead to changes in the psyche, thus furthering emotional, cognitive, physical and social integration for an individual (Levy, 2007; adta.com). DMT is understood in this research paper as a branch of Somatic Psychology, an interdisciplinary field that studies the therapeutic interaction of the body (“soma”, from ancient Greek, meaning “body”) and the mind.

In recent years the fields of Neuroscience and Somatic Psychology have grown closer together. Neuroscientific findings are providing a basis and a guide for the

development of SP (LaPierre, 2006; Siegel, 2007; Siegel, 2012; Cozzolino, 2010). The interplay between neuroscience and SP in the clinical setting became apparent in this research study, as all three participants drew from both disciplines to describe sexual trauma and its implications. The concepts of nervous system regulation, attachment system, and self-protective system are used by the participants of this study in a way that is informed both by SP theories and neuroscientific findings. Neuroscience and its understanding of the memory systems also provided a rationale for the design of this study. The underlying hypothesis of this research is that DMT, as a SP modality and with a neuroscientific correlate, is an optimal approach for working with sexual trauma.

Literature Review

Sexual abuse and assault is an experience of pervasive trauma that affects aspects of a person's emotional, physical and behavioral functioning. As previously stated, it is a worldwide social problem that despite evidencing unique characteristics in each culture crosses cultural boundaries (Spring, 2007; Brook, 2007). Prior research and literature informed the design and rationale for this study. To provide a context, several themes in relation to the processing of trauma and traumatic memories are briefly presented. The use of somatic and creative therapies as a way to further integration and health is offered as an optimal modality to work with sexual abuse survivors. Themes that are presented include: explicit and implicit memory encoding and retrieval, the somatic consequences of trauma, the somatic implications of sexual abuse, and a review of the brief pre-existing literature on the subject of dance/movement therapy with survivors of sexual abuse.

Trauma literature indicates that untreated traumatic stress has disturbing consequences for the psychological and physical health, as well as the life expectancy of the survivor. The pervasiveness of trauma goes beyond the experience of a traumatic

incident: survivors are often continuously disturbed by implicit and explicit memories that invade their daily life and impact the way they relate to others, as well as themselves (Young 1992; Eberhard-Kaechele, 2012).

While explicit memory includes factual, autobiographical and time-stamped information, implicit memory stores perceptual, emotional, behavioral and bodily sensory memory. Research in the field of neuroscience indicates that memory of traumatic events is mainly non-verbal, somatic and implicit, and often times fragmented from the verbal, cognitive recollection. During a traumatic event, the excessive levels of cortisol released can block hippocampal processing of explicit memory. At the same time, the chemical impact of adrenaline and norepinephrine enhances the encoding of fear, emotions and body sensations by way of the amygdala. (Siegel, 2007; Siegel, 2012; Cozzolino, 2010; Perry, 1999; Rothschild, 2002) This block of explicit processing combined with increased implicit encoding often results in several fragmented body memories that are not accessible through verbal talk and cognition. Traumatic events impact the body and body memory: the brain registers body sensations that constitute emotions, physical states of arousal and activation, and movement patterns (i.e. fight, flight, freeze, faint). Sometimes the cognitive facts of the situation are encoded simultaneously, and other times they are not, leaving body memories that are unanchored in time, non-linear and often invade the present (Rothschild, 2002; Caldwell, 2012; Eberhard-Kaechele, 2012; Kruithoff, 2012). As a result, trauma researchers suggest that in order to target unconscious triggers and defense mechanisms such as dissociation and somatization, psychotherapeutic work must include the body, the moving of memory or bodily re-enactment, and sensory impressions. (Schore, 2003; Levine & Frederick, 1997; van der Kolk, 1994; Krantz & Pennebacker, 2007; Goodwin & Attias, 1999)

Sexual violation entails a perpetration to many aspects of a person's being. The body is invaded and abused, and emotional boundaries are broken. Many times survivors have experienced violence, a threat to their lives, psychological abuse and manipulation, a breach of family love and trust in cases of incest, and a shock to their nervous system. Survivors are usually left with physical and emotional scars, an injured self-concept and self-esteem, feelings of guilt, shame and confusion, depression, dissociative tendencies and self-hatred (Mills and Daniluk, 2002; Valentine, 2007; Dolan, 1991). Additionally, they are prone to relationship difficulties and sexual dysfunction (Bernstein, 1995; Ambra, 1995). Even though survivors' relationships with their bodies may be highly impacted and distorted, traditional approaches rarely address directly the embodied aspects of a client's psychosocial experience (Simonds, 1994), the client's relationship with their body, or the client's experience of living in their body (Mills and Danilik, 2002; Krantz & Pennebacker, 2007). Dance/movement therapy, as a somatic modality, works to retrieve and process implicit unconscious memories, feelings and motivations giving way to integration of conscious awareness and emotional and cognitive growth and functioning. DMT can also help restore a person's movement repertoire and body awareness, and to heal and deepen embodied experiences and body connection.

The research literature addressing DMT as an effective modality for treating sexual abuse survivors is limited. Articles are mainly theoretical (Bernstein, 1995; Valentine, 2007) and sometimes provide clinical examples (Goodill & Dulicai, 2007; Goodill, 1987). Research in this field also includes case studies (Frank, 1997; Silverman, 2007), phenomenological research (Mills & Daniluk, 2002), and qualitative research based on in-depth interviews (Ambra, 1995). The scarcity and date of these studies suggest that there is a lot to be gained from researching what dance/movement

therapists are currently doing to treat survivors of sexual assault. The developments in the field of neuroscience and the growth and evolution of the field of somatic psychotherapy may have fostered progress and refinement of somatic tools and interventions that this study aspires to uncover and explore.

Methods

In order to investigate what dance/movement therapists are currently doing to treat sexual trauma, a qualitative interview methodology was used in this study. Due to the nature and the scope of this study, convenience sampling was used to choose the three participants that were interviewed. The participants were recruited due to their extensive experience in SP modalities and their clinical experience working with sexual trauma. To provide more culturally competent findings, the researcher gathered information about the cultural background of all three participants and of the populations they have worked with. Participant A identified as a female Caucasian American and stated that she comes from working class. Her clinical experience includes work with sexually abused foster children at catholic community centers, and more recently a private practice where she works primarily with women in their thirties and forties. She also works with men and children, has some clients from other nationalities (Brazilian, Hispanic), and has clients that identify with diverse sexual orientations. As for her theoretical orientation, she is a somatic psychologist and has extensive training in Body-Mind Centering, an embodied approach to movement, body and consciousness, developed by Bonnie Bainbridge Cohen. Participant B identified as a female European American. She stated most of her clients have been Caucasian women, although she has worked with Hispanic, African American and Asian American women as well. She has had clients that identified with diverse sexual orientation, and some clients that identified as trans. Her clinical experience involves

several years of working at a counseling center for domestic abuse and sexual violence, and in more recent years she has had a private practice focused on working with trauma. She is a dance/movement therapist and her theoretical orientation is deeply influenced by Peter Levine's work: Somatic Experiencing, Eye Movement Desensitization and Reprocessing Therapy, and Susan Aposhyan's work: Body-Mind Psychotherapy. Participant C identified as a Caucasian American female from a privileged background. Her clients are mostly Caucasian, although she has worked with clients from different cultural and ethnic backgrounds. She has worked with trans kids and adults, and adults that identify with diverse sexual orientations. She is a dance/movement therapist and she has been working with and teaching Somatic Experiencing for over 20 years. She has a private practice that focuses in working with trauma.

The rationale for a qualitative interview approach was to collect current and in-depth information about the research subject. The researcher conducted semi-structured interviews with the goal of identifying themes of therapeutic material that commonly arise for clients who have experienced sexual trauma, and body and movement based interventions that are intended to facilitate the processing of this material. The potential findings of this research are intended to provide a resource for somatic psychotherapists who work with clients who have experienced sexual trauma, as well as a resource for therapists that follow other modalities and wish to incorporate body-based work into their therapeutic process.

The semi-structured interview process was based on Seidman's (2006) in-depth phenomenological-based interview approach. A series of four open-ended questions was used as a guideline to interview the three participants. The first portion of the interviews involved establishing a culturally competent professional history of each participant, thus establishing their theoretical orientation and clinical experience. The

second portion focused on uncovering common themes of therapeutic material that arise in working with sexual trauma. The final portion of the interviews focused on discussing somatic interventions that the participants utilize to work with sexual trauma in general, and somatic interventions that they use to address the specific themes that arose from the second portion of the interview. Semi-structured interviewing was preferred for this study as it allowed a fluid and rich conversation that supported the uncovering of therapeutic themes and interventions.

The data collected during the interview process was voice recorded and then transcribed into a written document. The written data was analyzed and coded through several rounds of linking, organization and meaning making. Data analysis resulted in different levels of thematic material that were organized and labeled by the researcher. Results are presented in the subsequent section.

Results

The data analysis provided several pieces of information that were categorized into superthemes, themes and subthemes of therapeutic approach and thematic material, and themes and subthemes of therapeutic interventions. This categorization of the results obtained from the three participants' interviews provided a conceptualization of sexual trauma and of the goals of treatment from a somatic perspective, four principles of somatic approach, fifteen themes of therapeutic material, and nine interventions to process trauma and further therapeutic growth.

Conceptualization of sexual trauma and of the goals of treatment

All three participants stressed that sexual trauma is relational, and complex at a physiological level. Three physiological and psychological systems are involved in this type of trauma: participant C reported this explicitly, and participants A and B spoke about all three systems indirectly. The systems that can be impacted as a result of sexual

trauma are the self-protective system, the attachment system and the reproductive system. The self-protective system is regulated by the reptilian brain and is in charge of orienting to threat and deciding weather to fight, flight or freeze, based on what it predicts will give the individual the highest chance of survival. As participant C explains, incomplete self-protective responses can make survivors hypervigilant and scared, and keep the nervous system over activated. The attachment system is particularly compromised when the abuse is incestuous or the perpetrator is someone known to the victim. As participants A and C explained, the attachment system overrides the self-protective system, and the interaction between these two systems that create opposite impulses is highly complex. Lastly, the reproductive system is activated in sexual assault, adding a third layer of complexity to this type of relational trauma. The activation of the reproductive system can affect arousal, sexual desires, and in cases of child sexual abuse awaken sexual impulses at an age that is not psychologically appropriate.

The goal of treatment, from a somatic perspective, involves teasing apart and attending to all these different systems, without judging or polarizing the impulses that stem from them. “The work involves acknowledging all three, holding them all simultaneously. The nature of trauma is polarization and splitting, and in order to repair you need to hold all these pieces together” (Participant C). All three participants explained that the work involves keeping the nervous system regulated and in a range of resiliency, attending to impulses and helping them sequence, and integrating the complexity of the experience at a somatic, physiological and psychological level.

Principles of somatic approach

Four principles were identified as overarching themes that determine DMT’s approach to working with sexual trauma. These principles guide the therapeutic work

from a theoretical perspective and impact the progression of therapy at a practical and experiential level. The principles are: resourcing before getting into the trauma; pendulating between resource and traumatic material to keep the nervous system regulated; taking a client led, therapist directed approach, and working with what is present and charged for the client; and utilizing psycho-education to normalize the experience and empower the client.

Resourcing.

All three participants stressed the importance of resourcing clients before going into traumatic or activating material. Participant B explained that the foundation of trauma work is resourcing: this involves creating enough internal safety in the body-mind system that the individual can start to slowly approach the traumatic material with choice. It creates in the individual a sense of trust in their own body, a sense that they can find their way back to a place of calm if they get triggered or overactivated. Participant C reported that before talking about any traumatic material she identifies strengths and resources for the client: "I do not do anything until I've gotten a very visceral resource in place". Having resources in place keeps the process in a range of resiliency for the client, where they are feeling the distress proportionately to the resource. Participant A also explained: "you need to build potency before you can look at collapse, (…) you have to have resources before you can go toward discomfort".

Pendulating.

Once resources are identified and in place, trauma work involves pendulating between the resource and the distress as a way to keep the nervous system in a range of resiliency. Participants B and C spoke about importing resources and looping clients back to the resource to increase safety and further integration. Participant C explained that the goal is to get clients eventually pendulating on their own, moving fluidly

between the distress and the resource. Pendulating prevents going too far into a distress, which would take the client's nervous system through a stress pattern that they have been through too many times before.

Client led, therapist directed approach.

Working with what is present in the moment and following the client's lead is a fundamental DMT principle (Levy, 2007). All three participants spoke about trusting the inherent wisdom of the client and supporting the sequencing of impulses. This does not mean simply witnessing the client, but leading the progression, slowing it down, taking cues from the client and helping them pendulate. Participant A stated that she works with what is present in the moment because this is where the charge is for an individual, this is where something can develop. Participant B spoke about giving the client choice as to how they want to participate, what they want to say about a certain topic. As participant C put it: "it is client led in the sense that I am taking all my cues from the client, but I am very strategic about where I go and when in order to stay in that range of resiliency for a person".

Psycho-education.

Participants reported utilizing psycho-education to engage clients' curiosity, to get them involved in their own healing process, to educate about the nervous system to enhance feelings of empowerment, and to normalize experiences to diminish the weight of shame, guilt and judgment. In the lines of Chace's perspective on mental illness, Participant A explained that people are intelligent and if they are given the resources and the support, their own intelligence helps them solve what they want to solve (Levy, 2007). Participants pointed out that they teach to what happened in the session to make learning integrative and relevant. Participants also reported that they teach about the

body, the nervous system and the memory systems in order to work with clients who present resistant to somatic work.

Themes of therapeutic material

Fifteen themes of therapeutic material were identified as a result of the interview process. These themes refer to topics that the participants reported show up commonly for clients with sexual trauma. Not all of these themes show up for every client. Moreover, this list is not intended to extensively cover every theme that can arise in working with sexual trauma, but to provide a sense of major themes that usually show up in the therapeutic setting. Six themes were mentioned by all three participants. These are: depression/anxiety; relationship issues; hypervigilence/a sense of freeze/a sense of dysregulation; sexual issues; shame/guilt; dissociation. Five themes were mentioned by at least two of the participants. These are: fear of men/impact on sexual orientation; boundaries; physiological problems; confusion; poor body awareness. Four themes were mentioned by only one participant. These are: suicidality/safety; secrecy, hiding/not wanting to be seen; manipulation.

Fig. 1: Emergent themes of therapeutic material

Interventions

Data analysis yielded several interventions and experiential exercises that DMTs use to work with sexual trauma. These interventions were organized into 9 categories.

Resourcing.

Resourcing is not only a somatic principle, but also an intervention to regulate the nervous system when it gets hyperaroused. Participants provided several examples of somatic resources and resourcing exercises.

Orienting.

In this intervention, the therapist asks the client to orient to the room. The therapist might ask client to look around the room, find something they are drawn to and observe it and/or describe it. This intervention increases safety, since it gives the client a moment to realize that they are safe in the room; it awakens the senses and brings the client's awareness into the present moment; and it draws attention away from the body when the body is a source of activation.

Allies.

Allies are real, imagined, mythological or spiritual beings that the client can identify as friends, supporters and/or protectors. As an intervention, a therapist can import the resource of an ally into a situation where the client needs support. The therapist might ask a client to modify an image from the traumatic event by imagining there is an ally or protector there with them. The therapist might encourage the client to imagine how the sequence of events is different when the ally is present, and what they notice in their body when the ally steps in to protect them.

Self-touch.

In this intervention, the therapist invites a client to place their hands over a part of their body that needs support, holding or contact. The therapist might use this intervention to provide a resource for a part of the body that is experiencing distress, or to reinforce the sensation of a part of the body that is experiencing relaxation or joy.

Grounding.

Grounding exercises focus on encouraging a client to pay attention to the sensation of their body against the couch or chair, on feeling the weight of their body drop down, on deepening exhalations, and on feeling the sensation of the feet on the ground. This intervention is a regulating exercise that can assist the themes of hypervigilance, dissociation, and poor body awareness.

Body scan focused on resources.

In this exercise the therapist guides the client's attention through different body parts, focusing on the parts of the body that feel good or neutral. If there is a body part that is activating for the client, the therapist might skip this part when the intention is to resource.

Walking.

Walking forces the joints to move, and this can support a client in shifting states. Additionally, the movement can sequence energy and support regulation.

Telling a story/ a funny story.

In this intervention, the therapist asks the client to tell them a story. This supports blood flow toward the frontal cortex and away from the reptilian brain. This intervention is particularly useful when a client is hyperaroused, frozen or dissociating.

Interview about fundamental resources.

In this intervention, the therapist interviews the client about what is important to them, what they are passionate about or what they love. As Participant C explains, if they are coming to therapy, there must be something they want, or something they don't want to loose. The exercise consists of asking about this resource and orienting the client to the body sensations that arise when they connect with that resource.

Boundary exercises

Sexual abuse involves a perpetration of physical and emotional boundaries. Reclaiming personal boundaries at a conscious and unconscious level is fundamental to support clients' sense of safety, and to work with relationship issues, hypervigilence and body awareness. When the experience of sexual assault was repetitive or when the perpetrator was someone known to the victim there is a high likelihood that clients will find this dynamic familiar, being more prone to recreate this relational dynamic. Working with boundaries is especially important in these cases, as perpetrators can come into the field of these clients without and internal alarm going off.

Participants described a number of exercises to strengthen boundaries and support clients with relationship issues.

Saying "no".

The therapist might encourage a client to practice saying "no" by using their voice, or by physically pushing. Participants reported they conduct this exercise asking the client push with their hands, with their legs or with their whole body. The client might push against a physio ball, against a wall, against the therapist's body if there is consent, or against a pillow that the therapist is holding.

Move toward and away.

In this exercise therapist and client interact. One person stands still, and the other person moves toward and away from the still person. The person that stands still can ask the person that moves to move toward them, to stop, to move away from them, or to move in different speeds. The person that is still pays attention to the sensations in their body to figure out how close is too close, and where the optimal distance is. Variations of this exercise include playing with different levels (ie: crawling, shifting

heights), and with facing (ie: the still person can be approached from the front, from the side, from a diagonal).

Facing and spacing.

In this intervention, the therapist supports the client in finding comfortable facing and spacing in the room. The therapist might ask the client "where do you want me in the room?", or might explore different spatial settings. Participant B reported working with a client that wanted her to sit on the floor right next to the client's chair: "there was something about being lower and being off to the side that helped her relax". This exercise helps build awareness of the body, work with boundaries, and have clients feel in control and that they have choice. This intervention can also be useful if a client is overactivated and needs space. Participant B explained that when one of her clients would get too activated she would move away from them, or look away, all the while talking to the client to maintain contact. She would come back to her seat when the client stated they were ready and wanted her to come back.

Becoming comfortable with body sensations.

A fundamental part of somatic therapy involves raising body awareness, helping clients become comfortable or tolerate body sensations, letting sensations move as opposed to stopping them, and exploring sensations without the need to find an answer. All three participants explained that an important intervention is to help clients slow down and explore sensations. This involves asking clients to notice, locate and describe sensations. The therapist can support the client, via verbal coaching and somatic empathic mirroring, in suspending judgments about what they are feeling and in staying open and curious. The therapist can notice movement patterns and make them overt, and can suggest the client breathe more fully. Participant A stated that she looks at "moving/expressing/sensing: what needs to happen next?"

Telling the story from the physiology.

All three participants talked about the nervous system extensively, and described that one of their main jobs is to help the client bring impulses and self-protective responses back online, and help impulses sequence. This involves going through the story of the abuse, paying attention to what the client wanted to do or wanted to have happen and completing that through movement or imagery. Participant C explained that in threat response the first thing an individual needs to do is orient to the threat to be able to see it coming and assess it's potential danger. In cases where this did not get to happen, she will have the client do an imagery exercise: the client goes back to the moment before the assault happened and imagines locating the perpetrator, freezing them, setting them as far away as they want to, and having a moment to orient to the threat. She will then ask the client to notice what their impulse is, and allow them to sequence this impulse through movement or in their mind's eye.

Participant C also stated that she will ask clients "when did you first realize that something was wrong?". She confirmed that in most cases clients remember having a sense that something was off before the assault happened. In this exercise, she will have the client imagine that moment and really pay attention to their alert system that was signaling something didn't feel quite right. She stressed that she provides psycho education to normalize the fact that many times we are taught to be nice and not to listen to our instincts, but it can be very empowering to the client to notice that they actually did know that something was wrong. Through exploring body sensations and paying attention to impulses, she teaches clients to notice these gut feelings and pay attention to them.

Participants B and C described taking the client through the story of the abuse with a focus on noticing what their physiology wanted to do, and having them imagine

doing it and having a different outcome. This process involves slowing the story down, bringing awareness to sensation, movement and impulses, importing resources when needed (i.e.: imagining an ally or protector could step into the scene), and helping clients feel what happens in their body when they imagine sequencing these impulses or having a different outcome. As Participant C reported: "I'm not taking people back through their trauma, I'm taking them through what their physiology wanted to do, and its very satisfying! People don't generally walk out of my office bummed, they leave feeling empowered and stronger and physiologically like their self-protective responses are online".

Differentiation without polarization.

Given that sexual abuse results in complex relational trauma it becomes important to help clients tease apart different emotions, sensations and impulses, without polarizing them. Clients many times feel a complex mix of emotions towards the perpetrator and the abuse. All three participants, when talking about incestuous sexual abuse, explained that, at the same time, there is a part of the victim that feels angry/hurt/sad/scared, and a part of the victim that feels love/care/need/attached to the perpetrator. In order to work with clients it is important to hold all these pieces simultaneously, and give clients permission to feel different and seemingly conflicting emotions. Aside from naming it, normalizing it and holding a non-judgmental stance, this coexistence of emotions can be worked with by locating the different emotions in the body. As participants reported, it is very common that clients will report feeling these emotions in different places in their body. The therapist can then ask the client to hold these sensations at the same time and notice how they coexist. This exercise of differentiation and integration is particularly relevant to work with feelings of guilt, shame and confusion.

Encapsulated fragment.

Participants reported that sometime there is a fragment of the client that is still stuck in the trauma. They will prompt the client with questions like “Is it okay to feel safe if you are safe?”, “What is it like to hear ‘you survived’, or ‘it wasn’t your fault’? Is there a part of you that isn’t getting the message?”. Participant C called this an encapsulated child, explaining that it is like a time capsule that isn’t synching up with the present moment. Participant B explained this as speaking to a more unconscious part and helping the client update their files and bringing them into present moment awareness. The therapist might facilitate a dialogue with the part of the client that is an encapsulated child, that is stuck in the trauma, or that hasn’t gotten the message. Through somatic work the client can get a sense of what that part needs to receive or to hear, and through imagery they can imagine giving this to the part that is in need. The therapist can then encourage the client to feel into what happens to this part when it receives this, and what happens to the client as they witness this part getting attention, care and holding. This intervention can look like inner child work or Gestalt parts work, but always following the client’s impulses and helping them integrate the experience at a body level.

Working with dissociation.

All participants stressed that survivors of sexual abuse tend to be a highly dissociative population. Participants offered several interventions to work with dissociation. As a general guideline, the therapist can name it, describe the dissociation happening, not judge it, and slowly help the client come back. Participant A suggested naming the dissociation: “it feels like you are floating away, I am just going to draw a big circle around you so no piece of you gets lost”. She described attuning through the use of her voice, verbally maintaining contact and helping them land. Participant B

suggested asking the client where they are and asking them to describe it. If they are outside their body looking at their body, she will asks how this feels. She might ask them to move closer and further away from their body and notice what that is like, and she might ask them what they need to feel safe and come back to their body. She stressed that dissociation happens because there is a lack of safety, so one approach is to import resources, slow down and increase safety. Participant C described holding a non-judgmental stance. She explained that, many times, dissociating is how the client survived, so it is important to her not to shame it or make it wrong. She explained that, if it is not coupled with fear, immobility can be a quite pleasurable state. In this sense, she helps the client learn how to come back, and also use dissociation as a resource if it is one. She offered an intervention she attributed to Peter Levine, which involves telling the client the story of a freeze melting (i.e.: "so it was Alaska, it was winter, and the sun shined and the ice started to melt, and water was dripping…"), as to metaphorically help them unfreeze and come back.

Use of props.

All three participants reported using props to illustrate concepts, assist interventions, and provide a different and new medium to observe the process, the story, or what is stuck. Participants suggested using props to externalize the experience via sand tray, psychodrama and/or drawing. Hoses, pillows and balls can be useful to work with aggression. Participant A reported having a tent, and pillows and blankets in her office, and described clients using them to hide or build a fort. She also has stuffed animals to support clients in externalizing their story or observe their family dynamic. Participant C uses slinkys and squeeze dolls to illustrate concepts of activation and repression. Participant B reported using ropes, hula-hoops and boundary materials to

work with boundaries, and utilizing diverse art supplies to assist expressive and creative interventions.

Empowering the client.

Since sexual abuse entails a profound loss of power and choice, part of the therapeutic healing process involves helping the client feel in control and that they have choice. As an intervention, this can take the form of respecting the client's pace, giving them choice, asking them how they want to participate, and asking them what *they* want to say about their trauma. Participant B stressed the importance of always asking permission before giving feedback or conducting an intervention. Participant A explained the importance of apologizing to the client if she ever feels like she made a mistake. Many times clients have not had the experience of someone in power acknowledging a mistake and apologizing, and this can be a profoundly healing experience.

Discussion and concluding thoughts

The purpose of this study was to uncover common themes of therapeutic material that arise in working with clients with sexual trauma, and to identify and describe somatic interventions that DMTs are currently utilizing to address and process these themes, and to further therapeutic growth and personal integration. The goal of this research and of this paper is to provide a rationale as to why DMT as a SP modality is an optimal approach for addressing and working with sexual trauma, and to provide clinicians with concrete body-based exercises and interventions they can incorporate into their work. Additionally, identifying common themes of therapeutic material for this population carried the intention of making several potential issues overt, thus potentially supporting clinicians in identifying their blind spots or shadow spots. Lastly,

this research aimed to provide somatic theory and practice to non-somatic therapist that wish to incorporate a body-based lens into their work.

Due to the scope of this study there were several limitations present. Future research could identify a more culturally diverse population to utilize as participants of the study. This research also defined sexual abuse as any sort of non-consensual sexual contact, mostly disregarding the differences between rape, incest, date rape, one time versus repetitive or ritualistic abuse, and differences in age and gender. This research also did not discuss the potential presence of other diagnosis in addition to sexual trauma. Future research could hone down on these differences and its implications. This research study also did not focus on group work, but rather on an individual therapy setting. Group work has the potential of being a strong catalyst for change and integration, and further research could focus on uncovering themes and interventions that are present in sexual abuse survivor therapy groups.

As a final consideration, it is important to point out that every interventions described in this research paper is intended to be an example of somatic work and body-based exercises. Clinicians should use their clinical judgment and professional rationale determining if these exercises are appropriate for a certain client at a certain time in treatment, and if the skills needed to conduct these interventions are in the scope of their practice.

The process of working therapeutically with a person's deep trauma can be a profoundly humbling and intimate experience. All three participants spoke about the role of creativity in their work, stating that there are never two clients who have the same response to a situation, that have survived it in the same way, or that have the same ideas about what they need to heal. The role of the therapist is to remain open and curious, trust the client and the process, and avoid making assumptions that limit the

range of possibilities. Given that trauma is in the body, the fundamental aim of the somatic therapist is to recreate safety in the client's body, helping them trust their impulses, their sensations, and themselves.

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