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Untying the Knots: Dance/Movement Therapy with a Family Exposed to Domestic Violence

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Abstract Domestic violence affects not only the battered victim, but all members of the family. Dance/movement therapy, through its active and metaphorical process, can provide a new therapeutic approach to assist families exposed to domestic violence. This paper provides a case illustration of the use of dance/movement therapy with a family exposed to domestic violence, as the primary therapeutic intervention. It is grounded in theories of attachment, on the primary hypothesis that dance/movement therapy offers not only a way to address the physical and emotional patterns of immobilization but also, as a reparative tool, it assists victims in integrating healthy self-regulatory capacities that have been stunted by trauma experienced through the body. The case illustration highlights how dance/movement therapy provided a direct approach to addressing specific symptoms of abuse that appeared in particular individuals in this family, as well as how "re-choreographing" the family dynamics and relationships dysregulated by the domestic violence was pivotal in helping this family to learn new ways to self-regulate.

Keywords Dance/movement therapy · Domestic violence · Trauma · Family therapy · Attachment theory · Affect regulation

Introduction

Domestic violence affects not only the battered victim, but all members of the family, including the children who witness it. Traditional therapeutic approaches with domestic violence often focus on immediate crisis-centered work, assisting with practical, legal, and safety issues, restoring the victim's self-esteem, building a support network, and breaking isolation and secrecy (NiCarthy, 1982; Walker,

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1991). Once immediate safety and crisis issues are addressed, however, less emphasis is placed on working therapeutically with other victims in the family as a unit. If the household composition shifts, relationships, dynamics, and roles are further re-arranged, and family members may have a significantly difficult time orienting to the new environment. The chaos once present during the violence often reverberates throughout the family, creating additional struggles. Dance/movement therapy, through its active and metaphorical process, can provide a new therapeutic approach to assist families exposed to domestic violence and reorient family members to their new roles in the family system. Furthermore, since domestic violence influences environmental and bodily safety, advances in neurobiology have emphasized the importance of including the body in treatment of any type of trauma (Levine & Frederick, 1997; Rothschild, 2000; Schore, 2003; Siegel 1999a; van der Kolk, McFarlane, & Weisaeth, 1996). According to Moore (2006), "the sensations and actions that have become stuck in and after a traumatic event need to be integrated in the treatment process, so that the person can regain a sense of familiarity and efficacy in the body" (p. 106).

This expanded knowledge has broadened the ways in which dance/movement therapists intervene to support children and families to move forward from common patterns of "immobilization" often experienced in victims of domestic violence (Leventhal & Chang, 1991), develop and build body awareness (Moore, 2006), and build the presence of physical contact or "bonding" in families (Sbiglio, 2006), which can assist in enhancing the security of attachment relationships within the family unit.

This paper provides a case illustration of the use of dance/movement therapy as the primary intervention with a family exposed to domestic violence. It is grounded in theories of attachment, on the primary hypothesis that dance/movement therapy offers not only a way to address the physical and behavioral patterns of immobilization (Leventhal & Chang, 1991), but also, as a reparative tool, it assists victims in integrating healthy self-regulatory capacities that have been stunted by trauma experienced through the body (Gray, 2001; Levine & Frederick, 1997; Rothschild, 2000; Schore, 2003). The case illustration highlights how dance/movement therapy provided a direct approach to addressing specific symptoms of abuse that appeared in particular individuals in this family, as well as how "re-choreographing" the family dynamics and relationships dysregulated by the domestic violence was pivotal in helping this family to learn new ways to self-regulate.

Theoretical Perspective: Attachment and Regulation

The experience of trauma can lead to a number of cognitive and affective symptoms, including: intrusive thoughts, feelings and images, restricted affect, avoidance of cues associated with the trauma, dissociative symptoms, and hyperarousal or hypervigilance (American Psychiatric Association, 2000). In addition, repeated trauma that occurs in the context of relationships severely affects a victim's capacity for forming meaningful/intimate relationships with others (Herman, 1992). Clearly, domestic violence is a traumatizing experience that is often persistent and cyclical

and has a range of negative consequences for its victims. Research has also repeatedly shown that battered women display significantly more trauma symptoms than non-battered women (Campbell, 2002). There are also indications that children who have witnessed physical abuse between parents are at higher risk than other children for experiencing emotional and conduct disturbance as well as deterioration in peer and family relations (Wolak & Finkelhor, 1998). Additionally, children exposed to domestic violence manifest greater difficulties in developing empathy and verbal abilities than those who are not (Graham-Bermann & Levendosky, 1998; Huth-Bocks, Levendosky, & Semel, 2001).

Emerging literature suggests that attachment theory, which emphasizes that development occurs based on experiences and interactions children have with their primary caregivers (Bowlby, 1988), has much to offer in understanding domestic violence (Lyons-Ruth & Jacobvitz, 1999). LeDoux (2002) suggests that if a significant portion of a child's emotional experiences is due to activation of the fear system rather than a positive system, then the characteristic personality that begins to unfold is often characterized by negativity and hopelessness rather than affection and optimism. Lyons-Ruth and Jacobvitz (1999) suggest that "the fear, anger, and unregulated physiological arousal resulting from frustration of attachment goals and the intergenerational transmission of relational patterns" (p. 541) needs to be taken into account in any view of violence and abuse.

Attachment theory is an influential concept by which to understand parent/child interactions (Ainsworth, Blehar, Walters, & Wall, 1978; Bowlby, 1969, 1988; Lieberman & Zeanah, 1999) and has many implications for clinical application. While attachment theory has been incorporated into a variety of other theories, its fundamental construct remains a biologically-based predisposition for proximity and attachment between mother and child (Bowlby, 1988), in which security of attachment predicts later functioning.

As developed by Bowlby (1969) and elaborated by Ainsworth et al. (1978), attachment theory emphasizes that variations in *attachment security* are rooted in patterns of early caregiving. Ainsworth et al. (1978) broadly divided these individual differences in quality of attachment relationships into two categories: "secure" or "insecure." These variations in security describe the "infant's apparent perception of the availability of the caregiver if a need for comfort or protection should arise, and the organization of the infant's responses to the caregiver in light of those perceptions of availability" (Weinfield, Sroufe, Egland, & Carlson, 1999, p. 69). These internalized models of caring have significant implications for the child's later emotional and social development.

Humans are born with a brain system that promotes safety by establishing an instinctive behavioral bond with their mothers (Siegel, 1999a) and also produces "distress when a mother is absent, as well as a drive for the two to seek each other out when the child is frightened or in pain" (Lewis, Amini, & Lannon, 2000, p. 70). A child uses its attachment figure (usually a parent) as a secure base from which to venture out and explore, and a safe haven to return to in times of danger (Bowlby, 1988). However, for children who are exposed to the trauma of domestic violence, the protective qualities of comfort and safety present in the home environment are highly disturbed.

In the vignette that follows, we can assume that one of the child's attachment figures (the identified abuser) could have been the direct source of terror and alarm. In addition, because of her own struggles, the capacity of the mother (the other parent) to be emotionally available was diminished, or slow, or inconsistent in responding to her children's needs. According to Lyons-Ruth and Jacobvitz (1999), "when cues in the current environment activate these unintegrated trauma-related representations, fear-related maternal behaviors occur out of context and are therefore inexplicable to the infant. Such behaviors are likely to alarm the infant" (p. 549). Since children rely on their attachment figures to soothe states of distress, when danger threatens, as in domestic violence situations, fears stemming from their own caregivers place the children in an unresolvable paradox.

The aforementioned literature speaks to the significance that caregivers and therapists have for such children. Perry (2003) describes the importance of this type of connection or experiences and how it physiologically affects our biological systems:

> When you look at someone, when you hear someone, when you have a conversation, when you make a joke with somebody, when you touch someone, every single one of those physical interactions are translated into patterned neuronal activity that go into the brain of both people in that interaction and result in positive changes. These physical changes influence our immune system and they influence the autonomic nervous system that controls your heart and your lungs and your gut. Literally, when people have relationships that are of good quality, these individuals are actually physically healthier, they're emotionally healthier, they're more cognitively enriched, and they actually reach their potential to be humane in ways that are impossible without relationships (p. 5).

The relationship of the caregiver to the child has an impact not only on the emotional elements of the child's development, but also on its biological health. For example, in the case of Cathy, an 8-year-old who witnessed several shocking incidents (such as her father physically grabbing her mother's hair, dragging her mother across the floor and proceeding to physically assault her until she had two black eyes), often complained of somatic symptoms (i.e., headaches, stomach aches, and severe constipation). In addition, she was hypervigilant, had difficulty sleeping, and struggled to focus at school. Cathy clearly had physically internalized many of her feelings, and struggled both verbally and nonverbally to express them. During dance/movement therapy sessions, Cathy's internalized anxiety was seen through hypermobile energy. She would move quickly around the room, fall and flop on the floor, and burst into spontaneous laughter, especially during times when her body was encouraged to become passive and relax. Being in her body initiated many fearful sensations, and she used those defenses to avoid experiencing them.

Mainstream psychotherapy addresses the cognitive and emotional elements of trauma, but lacks techniques that work directly with the physiological elements despite the fact that trauma profoundly affects the body (van der Kolk et al., 1996). As illustrated in Cathy's case, her symptoms of trauma were somatically based (i.e., headaches, severe constipation, stomach aches). The concept of regulation and its

correlation with the development of secure attachment (Hofer, 1984; Schore, 2001, 2003) is a further step at assisting victims to begin to establish a healthier relationship to their internal sensations and emotional experiences.

Affect Regulation

Neuropsychological research suggests that the primary caretaker serves as a "psychobiological regulator" (Schore, 2003) for the developing child. In this capacity, the caretaker helps to modulate the child's levels of arousal to facilitate *self-regulation*, not only of behavioral rhythms, but also of physiological rhythms, including autonomic, neurochemical, and hormonal functions (Hofer, 1984; Lewis et al., 2000; Schore, 2003; Siegel, 1999a).

When emotional energy is exchanged between two people, their internal worlds mutually resonate. During these moments potent with affect, mother and child help regulate and transform each other's internal and external worlds. The child feels these experiences. At the same time the child feels them, the child senses the feeling of the other. It is the sharing and *interactive/mutual regulation* during these times of shared moments that mother and child become attuned in a synchronistic nonverbal exchange (Stern, 1985, 2003; Trevarthen, 1977). These shared experiences enhance the initial bond developed by child and mother.

In growth-enhancing environments, good responses are mirrored and the child replies by creating a similar response. During this dyadic dance, the child and the mother join together in a state of co-regulation of affect. As the dance grows in complexity, the child is less dependent upon the mother and is able to develop the ability to *self-regulate.*

In contrast, when there are repetitive experiences of misattunement (such as a caretaker's inability to soothe a child's state of distress, the caretaker being the source of terror, or the caregiver's inability to read and respond to the child's cues—due to his or her own fears or preoccupations), the child becomes insecurely attached. Situations such as these occur too often in environments of domestic violence. Without an attuned responsive soothing by a reliable and consistent caregiver, such children do not learn to self-regulate and remain unable to restore their inner emotional equilibrium.

Lewis et al. (2000) asserts that:

> … people do not learn emotional modulation as they do geometry or the names of state capitals. They absorb the skill from living in the presence of an adept external modulator, and they learn it implicitly. Knowledge leaps the gap from one mind to the other, but the learner does not experience the transferred information as an explicit strategy. Instead, a spontaneous capacity germinates and becomes a natural part of the self, like knowing how to ride a bike or tie one's shoes (p. 171).

To enter into this communication, Schore (2003) asserts that the mother must be attuned not so much to the child's overt behavior as to the reflections of the rhythms of the child's internal state. According to Schore (2001), these affective attunements, both spontaneously and nonverbally, are "the moment-to-moment

expressions of the mother's regulatory functions occur at levels beneath awareness" (p. 14). This attunement is a kinesthetic and emotional sensing of others. It is a knowing of the child's rhythm, affect, and experience by metaphorically being in its skin. It goes beyond empathy to create a two-person experience of connectedness by providing a reciprocal affect and/or resonating response. Attunement is communicated by what is said as well as by facial or body movements, signaling to the child that his or her affect and needs are perceived, are significant, and make an impact on another (Meltzoff & Brooks, 2007; Schore, 2003; Trevarthen, 1977). Because many of these attuned interactions occur on a nonverbal level, dance/movement therapy can be an ideal treatment intervention in supporting the development of affective attunement.

The Family in Treatment

The "Jones" family consisted of the mother, Laurie (44), and her daughters, Nicole (12) and Sandra (9). On occasion, the individual therapists of each of the family members would meet simultaneously with the family to explore any particular family crisis or conflict that emerged and might require some family problem-solving. Such verbal interventions, however, often led to angry screaming outbursts and family dysregulation.

Laurie usually responded by intellectualizing, speaking with rapid pressured speech, and could not read or respond appropriately to her children's cues. Laurie often brought up situations which initiated stress, occurred because of the children's father (the identified abuser). When her children made attempts to assert their needs, or express their feelings, Laurie often became defensive, dismissive of her children's needs, or looked to the therapist for support in responding to her children's feelings.

In the verbal family therapy sessions, when Laurie discussed Sandra's destructive tantrums at home, Sandra had a tendency to become dissociative (e.g., blank stares, unresponsive at times to verbal cues, or extremely active and agitated, moving quickly around the room with no direct focus). Sandra responded this way in multiple settings, especially during times of heightened stress. Schore (2004) describes this kind of dissociative response as representing:

- a detachment from an unbearable situation;
- an escape when there is no escape;
- a last resort defense strategy.

Nicole also responded to stressful situations by withdrawing. She fluctuated between shutting down emotionally and verbally and becoming physically aggressive towards both her sister and her mother. It was as if her nervous system were constantly in a state of hyperarousal, not knowing whether it was time to "fight" or "flee." In addition, since the departure of the father (the identified abuser) from the home, Nicole, being the eldest child, was often placed in a mediating position during visitations, as the primary communicator between her mother and father. Since her father often undermined the mother's authority (e.g., belittling her

in front of the children, calling her names, disregarding any set limits, and returning the children from visitation on his own time schedule, despite any time boundaries arranged by the court), Nicole was indeed in a difficult situation.

In individual sessions, Nicole and her therapist identified this mediating position as being, metaphorically, the "rope" in a very hard game of "tug of war." She felt pulled in two directions, both sides equally pulling with the same force. Her father would have angry outbursts, and her mother would fall apart emotionally. Nicole felt stuck in the middle, with nowhere to go, feeling "pulled apart." In order to avoid any angry outbursts from her father, Nicole often sided with him, belittling her mother and her sister, emotionally shutting down, and internalizing her anxiety. She also often lashed out physically at her mother and her sister, as her father had done. Nicole's outbursts and increased physical aggression caused Nicole's mother, Laurie, to begin to be fearful of her daughter, and therefore Laurie was struggling to set any healthy limits and boundaries.

In addition to the individual defense strategies mentioned above, it appeared that the family had very limited experience with spontaneous play, causing the constantly present tension to be fairly palpable. Despite the absence of the identified abuser from the home environment, the remaining family members still carried tension and the family remained in a constant state of dysregulation. They experienced little joy together as a family unit and constantly struggled to communicate and manage their individual feelings.

Therapeutic Intervention

The family became involved in family dance/movement therapy sessions after each member of the family separately attended individual psychotherapy sessions for several months. Suggestions to use dance/movement therapy sessions to support the family were well received. Because verbal interventions alone had not enabled the family members to resonate with each other at the nonverbal level, it was deemed necessary for this family to experience their connections through the body. The goals of the dance/movement therapy work were:

- to identify and diffuse the ever-present family tension;
- to build healthier communication amongst family members;
- to re-choreograph this family's dynamics, crucial to the repair and correction of emotional experiences in the family unit.

The family had limited experience of attuned, affective communication. They constantly struggled with obvious family tensions and the children's explosive, aggressive outbursts. This home environment exacerbated the mother's own traumatic experience of domestic abuse; she became fearful of her children, shut down emotionally, and went into a frozen or immobile state. To cope, the children too, seemed to adopt similar immobilizations mechanisms, given their limited experience with responsive, early caregiving relationships. All family members, in varying degrees, had integrated this defense as the strategy for functioning and self-regulation.

Beginning Phase of Treatment

It was important for the dance/movement therapist to assess the family dynamics by joining in movement explorations, establishing a therapeutic movement relationship, and observing each family member's movement repertoire in relation to the others. For example, early on during the family dance/movement therapy sessions, while moving together in synchrony, the family and dance/movement therapist joined hands in a circle; slowly, the each member weaved in and out of the others until they spontaneously became tied in a "family knot." This metaphor of tension, struggle, and conflict resonated with them. The dance/movement therapist then encouraged the family to communicate with each other to explore ways to "untie the family knot." All family members responded metaphorically through movement explorations, as they would in other family struggles. Laurie stood still, as if immobile and frozen. She could not communicate verbally, nor see how to move out of the knot. Sandra began to move quickly and rapidly, without taking in the whole picture: this caused the family to become even more anxious. Nicole immediately began to tackle the problem independently, without support from anyone, not her sister, not the dance/movement therapist, nor even her mother. The spontaneous "family knot" that emerged through the movement process was a perfect metaphor, for at that moment, the family had a felt-sense of its tensions, not only how palpable their presence was, but also how much each member contributed to them. With the support of the dance/movement therapist, members of the family started to communicate with each other thus relieving pressure and tensions. The therapeutic process provided not only assistance in connecting the family, but also offered a metaphorical representation of how their family patterns emerged. With the dance/movement therapist's support, this family was able to physically move with the tension (while still connected) and together initiate a verbal and nonverbal dialogue toward developing new solutions for resolving family conflicts.

According to Ainsworth et al. (1978), children with insecure attachments resort to psychological defense mechanisms (e.g., relying only on themselves, not expecting to be soothed, cared for, or consoled by adults) to survive. It was important for this family's children to begin to develop a sense of safety in coming to their mother during times of distress. Both Nicole and Sandra were unable to trust the availability of such security and Laurie's capacity to support them in regulating their increased anxiety. In addition, Laurie tended to become immobile, or "freeze" and dissociate during such stressful experiences, which activated her own unregulated traumatic representations to the point of not being able to cope at all.

Treatment Progression

Through weekly family dance/movement therapy sessions, the therapist supported Laurie in becoming aware of her own "freeze" state, in reading and understanding her children's signals so as to respond or attune appropriately. For example, during one session in which all family members arrived in very different emotional states, the dance/movement therapist gave a directive for each member to define individual "space" and "boundaries" through physical exploration. The family was

encouraged to look around the room and move to a space in the room that felt comfortable. Each family member was given a roll of masking tape and encouraged to visually and physically define his/her own space by applying the masking tape to specific areas on the floor, paying attention to how much space each felt was needed that day. Both children immediately became engaged in this, running to the opposite corners of the room and marking out their own "spaces" with the masking tape, making adjustments as necessary. As this was happening, Laurie stood still, and appeared to be, again, in her freeze state. She just stared blankly at her children as they actively moved and carved out their own environments, enthusiastically creating their own imaginary boundaries. Nicole began to identify and label areas in order to have her boundaries recognized and respected: "Keep out," "Nicole's space only," "Knock first." Sandra created a large space, making sure that it was big enough for her whole body to move, sit, crawl, stand, and lie down. She also began to create imaginary areas that would increase her comfort: "This is where I sleep, this is where I relax, this is where I play." Her focus was on creating her own environment where she could release and be free of tension. It was also important to her that her space be in close proximity to her mother. This movement exercise allowed each of the family members to begin to establish their own boundaries in relation to each other.

As Laurie stood watching her children, the dance/movement therapist witnessed Laurie's immobility and, aided by her own internal experience, assisted Laurie in building awareness of her body's reaction. Immobile still, Laurie slowly began to cry and said, "I feel like there is no space for me." Despite there being a large open space in the room, where Laurie could carve out an area just for herself, she could not physically feel any space as her own. This metaphor of spatial confinement was reflective of ongoing struggles in the home environment. Laurie had not experienced defined boundaries within her own environment, especially under constant abuse from her spouse. She resorted to becoming submissive to his needs, and was stuck in a pattern of immobilization. Such a pattern was now also developing in her relationships with her children. According to Rothschild (2000), "since trauma is often the result of events that were in one way or another physically invasive, re-establishing the sense of boundary at the physical level will often reduce hyperarousal and increase feelings of control" (p. 146).

The dance/movement therapist assisted Laurie in carving out her own space, so that she was then able to experience connecting to her children from within her own, well-defined boundaries. Further, the children also began to physically experience their own boundaries and feelings as separate from their mother's, which created a much greater capacity to connect with each other. This was a meaningful step forward in assisting each of the family members in building healthier relationships.

The dance/movement therapy process continued weekly, with similar movement experiences. Some were initiated by the dance/movement therapist's directives, others spontaneously emerged through the family's development of their own family dances. Over the course of several months, the family began to make meaningful connections between the continually emerging metaphors of family tension and dysregulation to their own family struggles. The dance/movement

therapy sessions became an integral turning point in supporting the re-choreography of their family dynamics.

Additionally, during the family dance/movement therapy sessions, it was very important that the capacity to initiate spontaneous play was experienced as reciprocal in nature, with Laurie and the children interacting together. This meant that not just the children were to move while the adults were watching but, rather, that both children and mother were to use these joining opportunities as interactive reparative moments. Through the use of traditional dance/movement therapy techniques of mirroring, family members had the opportunity to initiate movement dances that were immediately mirrored (and their rhythms attuned to) by the other members of the family. Playful movement interactions such as trying on various body shapes, effort qualities, and rhythms were mirrored and reflected. During all this, the dance/movement therapist assisted the family in building awareness of the distinctions between not only mirroring the movements of each other, but also establishing a greater capacity to empathically communicate with each other. In essence, it was important for the family to physically experience the expressions of the other and reflect it back in a way which conveyed a deeper sense of validation, understanding, and communication. By using their own bodies in the movement process to affectively attune to each other's body cues, the family worked towards restoring and expanding each member's capacity for self-regulation while gaining an embodied sense of nonverbal empathy for one another. According to Chaiklin and Schmais (1993),

> There is a fine line between empathy on a movement level and mimicry. Mimicry involves duplicating the external shape of the movement without the emotional content that exists in the dynamics and in the subtle organization of the movement … Empathy meant sharing the essence of all nonverbal expression resulting in … direct communication" (p. 86).

Just as she did in her home environment, Laurie often struggled when moving in the role of leader. It was important for the dance/movement therapist to serve initially as the psychobiological regulator (Schore, 2003) for all members in the family, to label and identify the nonverbal cues presented by each. Thanks to this strategy, Laurie was increasingly able to stay present within her own affective experience; family communication and understanding could then begin.

In several sessions, this metaphor of struggling with direct communication patterns became thematic. During one session, for example, the family used a ball as a connection tool. At times, the ball moved easily and playfully between family members. One would throw it to another, and it would be caught with ease. The metaphor of receiving and initiating nonverbal messages, via the ball, was embodied. These "nonverbal messages" were easily delivered, with clear reciprocal receiving and sending. At other times, the "messages" were delivered to another quickly, with a harsh forceful throw. Sometimes, the messages were not received at all, and the ball remained "undelivered" on the floor, leaving the sender confused and hurt that the receiver did not accept the message. These movement metaphors allowed individual family members to express their styles of communication, reflect on their own experiences of sending and receiving important nonverbal cues, and

work in the movement process to develop strategies to deliver and receive communications more easily. In addition, the playful quality of these movement experiences allowed the family to incorporate humor, while looking deeper into the family tension, yet with fewer struggles.

Conclusion

Dance/movement therapy supported this family's needs by connecting to and highlighting their struggles through an active and metaphorical process. After several months of weekly family dance/movement therapy sessions, verbal communication problems lessened as they improved the ability to struggle nonverbally in movement. The capacity for each member of the family to engage in empathically attuned communications also increased significantly. Nicole was able to be more verbally assertive about her difficulties with being placed in the role of mediator. She became less dysregulated both in session and at home, and her physical aggression decreased. Sandra was better able to stay physically present without distancing herself internally when stressful topics were initiated. When anxiety arose, her increased trust in using her mother to assist in regulating her affect highlighted her expanded awareness of body cues and her capacity to use her body as a resource, which Rothschild (2000) describes as "the most practical tool in the treatment of trauma" (p. 100).

Furthermore, Laurie had begun to internalize and access her capacity for spontaneity and playfulness. There was more laughter both during the dance/movement therapy sessions and at home. Laurie developed increased awareness of her own body signals. Repeated experiences of attuned and empathically reflected movement through the therapeutic movement relationship, during the dance/movement therapy sessions, provided a reparative secure base which assisted her in developing her own capacity to provide more consistently attuned interactions with her children. All family members were working to repair and attune to each other's communications, initially disrupted and dysregulated during the presence of domestic violence, and still disturbed in its aftermath.

According to Siegel (1999b),

> When attuned communication is disrupted, as it inevitably is, repair of the rupture can be an important part of re-establishing the connection. Repair is healing as well as important in helping to teach the child that life is filled with inevitable moments of misunderstandings and missed connections that can be identified and connection created again (p. 51).

Schore (2003) stresses that the process of re-experiencing positive affect following a negative experience may help one internalize that negativity can be endured and conquered. Resilience emerges from an interactive context in which children and parents transition from positive affect to negative affect and then back to positive affect. Resilience, in the face of stress, is an ultimate indicator of attachment capacity and therefore adaptive mental health. The ability to regulate emotional states with flexibility through interactions with others, or without others,

as well as the resilient capacity to shift adaptively between these dual regulatory roles (Schore, 2003), were positive steps towards family repair.

Dance/movement therapists have a unique perspective when working with victims exposed to traumatic environments such as those in domestic violence situations. As highlighted by this case illustration, therapeutic approaches that work directly with the body provide new avenues for assisting victims of domestic violence through a simultaneously physical and metaphorical process. Increasing body awareness in victims of trauma makes it possible to "gauge, slow down, halt traumatic hyperarousal, and separate past from present" (Rothschild, 2000, p. 101). It is important to look directly at the family system in every stage of the domestic violence experience, especially after the departure of the identified abuser from the family environment. Reverberations of instability, insecurity, and established patterns for coping may need to be addressed as preventative measures to avoid further family disruption. Dance/movement therapists have a unique capacity to approach and re-choreograph these family struggles into expanding healthier attachment relationships.

References

Ainsworth, M., Blehar, M., Walters, E., & Wall, S. (1978). *Patterns of attachment*. Hillsdale, NJ: Erlbaum.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders-IV-test revision* (4th ed., rev.). Washington, DC: Author.

Bowlby, J. (1969). *Attachment and loss. Vol. 1: Attachment*. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. New York: Basic Books, Inc.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*, 1331–1336.

Chaiklin, S., & Schmais, C. (1993). The Chace approach to dance therapy. In S. Sandel, S. Chaiklin, & A. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 75–97). Columbia, MD: The Marian Chace Foundation of the American Dance Therapy Association.

Graham-Bermann, S., & Levendosky, A. (1998). Social functioning of preschool-age children whose mothers are emotionally and physically abused. *Journal of Emotional Abuse, 1*, 59–84.

Gray, A. (2001). The body remembers: Dance/movement therapy with an adult survivor of torture. *American Journal of Dance Therapy, 23*, 29–43.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*, 377–391.

Hofer, M. (1984). Relationships as regulators: A psychobiologic perspective on bereavement. *Psychosomatic Medicine, 46*(3), 183–197.

Huth-Bocks, A., Levendosky, A., & Semel, M. (2001). The direct and indirect effects of domestic violence on young children's intellectual functioning. *Journal of Family Violence, 16*, 269–290.

LeDoux, J. (2002). *Synaptic self: How our brains become who we are*. New York: Penguin Books.

Leventhal, F., & Chang, M. (1991). Dance/movement therapy with battered women: A paradigm of action. *American Journal of Dance Therapy, 13*, 131–145.

Levine, P., & Frederick, A. (1997). *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.

Lewis, T., Amini, F., & Lannon, R. (2000). *The general theory of love*. New York: Random House.

Lieberman, A. F., & Zeanah, G. H. (1999). Contributions of attachment theory to infant–parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment theory and research* (pp. 555–574). New York: Guilford Press.

Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment* (pp. 520–554). New York: Guilford.

Meltzoff, A. N., & Brooks, R. (2007). Intersubjectivity before language: Three windows on preverbal sharing. In S. Bråten (Ed.), *On being moved: From mirror neurons to empathy* (p. 149174). Amsterdam: John Benjamin Publishing Company.

Moore, C. (2006). Dance/movement therapy in the light of trauma: Research findings of a multidisciplinary project. In S. C. Koch & I. Bräuninger (Eds.), *Advances in Dance/movement therapy: Theoretical perspectives and empirical findings* (pp. 104–115). Berlin: Logos Verlag.

NiCarthy, G. (1982). *Getting free: A handbook for women in abusive relationships*. Seattle: The Seal Press.

Perry, B. (2003). *Nature and nurture of brain development: How early experience shapes child and culture.* Neighborhoods to Neurons Conference, 17–18 May 2003, Los Angeles, CA.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: W. W. Norton & Company, Inc.

Sbiglio, M. G. (2006). Dance/movement therapy and non-verbal assessment of family violence: A pilot comparative study. In S. C. Koch & I. Bräuninger (Eds.), *Advances in dance/movement therapy: Theoretical perspectives and empirical findings* (pp. 142–153). Berlin: Logos Verlag.

Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 7–66.

Schore, A. N. (2003). *Affect regulation and the repair of the self*. New York: Norton.

Schore, A.N. (2004, July 24). Lecture presented in *Developmental Psychoneurobiology*. Santa Barbara, CA: Santa Barbara Graduate Institute.

Siegel, D. (1999a). *The developing mind*. New York: Gilford Press.

Siegel, D. (1999b). Relationships and the developing mind. *Child Care Information Exchange, 11*, 48–51.

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Stern, D. (2003). *The present moment in psychotherapy and everyday life*. New York: W. W. Norton.

Trevarthen, C. (1977). Descriptive analyses of infant communicative behavior. In H. R. Schaffer (Ed.), *Studies of mother–infant interaction* (pp. 227–270). New York: Academic Press.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York, NY: The Guilford Press.

Walker, L. E. (1991). Post-traumatic stress disorder in women: Diagnosis and treatment of battered woman syndrome. *Psychotherapy, 28*(1), 21–29.

Weinfield, N. S., Sroufe, L. A., Egeland, B., & Carlson, E. A. (1999). The nature of individual differences in infant-caregiver attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment* (pp. 68–88). New York: Guilford.

Wolak, J., & Finkelhor, D. (1998). Children exposed to partner violence. In J. Jasinski & L. Williams (Eds.), *Partner violence: A comprehensive review of 20 years of research* (pp. 184–209). Thousand Oaks, CA: Sage.

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