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## Dance of Attachment: Dance/Movement Therapy with Children Adopted Out of Foster Care

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Dance of Attachment: Dance/Movement Therapy with Children

Adopted Out of Foster Care

Megan Haase

Submitted in partial completion of the

Master of Science Degree at Sarah Lawrence College

May 2019

### Abstract

This thesis is an investigative inquiry into the use of dance/movement therapy with children adopted out of foster care and their families. By focusing on the relevance of attachment and trauma with this population, this thesis draws connections between dance/movement therapy theoretical components and literature and the needs of this population. Children adopted out of foster care experience disrupted attachments and traumatic histories of separation, abuse, and neglect. As the literature illustrates, attachment and trauma are body-level experiences, and when addressing these issues, they must be approached through a modality that involves, engages, and values the body and the memories, interactions, and healing potential that it holds.

Dance/movement therapy presents as an ideal treatment for attachment and trauma-related issues, especially when working with children whose primary language and learning tool is movement. Dance/movement therapists have unique abilities to identify, assess, and address issues through the body and movement, and possess the potential to support former foster children and their adoptive families by using nonverbal means to build attachment, process experiences, and resolve trauma.

*Keywords:* dance/movement therapy, trauma, developmental trauma, attachment, abuse, neglect, adoption, adoptive families, attachment theory, foster care, foster children

## Table of Contents

Dedication .....	4
Introduction .....	5
Background on Foster Care and Consequent Adoptions .....	6
Background on Trauma.....	8
Background on Attachment .....	9
Developing Attachment: Moving Through the Body.....	12
The Impact of Poor Attachments and Traumatic Experiences.....	15
The Larger Societal Impact of Early Trauma and Poor Attachment .....	21
Caregiver Challenges in Building Attachment .....	22
Treating Attachment Problems .....	23
Goals of Treatment .....	25
Expressive Therapies .....	29
Dance/Movement Therapy .....	32
Dance/Movement Therapy and Children .....	33
Dance/Movement Therapy and Trauma .....	36
Dance/Movement Therapy, Attachment & Building Relationships .....	40
The Dance/Movement Therapist.....	42
Dance/Movement Therapy Interventions with Parents & Their Adopted Children .....	44
Discussion .....	46
Conclusion .....	52
References .....	53

**DEDICATION**

“Every kid is one caring adult away from being a success story.”

- Josh Shipp

This thesis is dedicated to my mom, one caring adult whose sacrifices, love and selflessness have, against all odds, made countless kids, including me, into success stories.

When my mother first became a foster parent, I naively assumed that I would watch these children's lives change before my eyes. I thought that being removed from the neglectful or abusive homes they came from would be a magic fix. With a mother like mine, all of their problems would soon disappear. I quickly realized that all of the bike rides, beautiful birthday parties, and bedtime stories in the world were not the instant solution I thought they would be.

All of a child's functioning boils down to their early-life experiences and attachment relationships (Bettman and Friedman, 2013; Bowlby 1969, 1988; Hughes, 2006; Perry, 2013). When a child is placed in foster care, no matter how much love and support they are showered with in a family, the deeply ingrained memories, hardships, and pain take a toll on their ability to grow healthily, learn, and love. My mom's adoption of my two younger sisters after a grueling 3-year journey in foster care led to our whole family falling in love with two toddlers who had difficult starts to their lives and whose early challenges manifested in their physical, emotional, social, and cognitive development. They deserve nothing less than a loving home that supports secure attachments, meets their needs, and gives them the services, care and resources that allow them to thrive.

Throughout this process, my mom demonstrated her strength and commitment to giving my sisters the best lives possible, but this was not done without challenges and obstacles. The trauma and damaged relational experiences in their early lives continue to influence their functioning, even after living with us for a majority of their lives and being adopted. Children and parents like my sisters and my mom deserve adequate treatment that addresses their unique needs, traumatic histories, and developmental abilities.

I am writing this thesis (often being interrupted with pokes, screaming, pillow fights, and requests for marshmallows) in honor of my mom and little sisters, who, like many members of

foster and adoptive families, embody strength and love that knows no boundaries. Families like ours, who endure the complex and taxing adoption process, could benefit immensely from all that Dance/Movement Therapy (DMT) has to offer. DMT empowers parents to speak to children through the universal language of movement, one they can actively participate in and understand. In doing this, DMT acts as a catalyst for change in all areas of a child's development, and especially within their healing of past trauma and development of attachment relationships. I have seen firsthand the challenges building attachment presents within the contexts of adoption and foster care, and affirm that DMT can play a powerful role in healing wounds, processing experiences, and moving forward together as a family. I feel immense pride in my family as I reflect on this challenging process, and am filled with gratitude for the opportunity to write about such a powerful topic, and for the privilege of calling the most beautiful, intelligent, and resilient four year olds I know, Malia and Maya, members of our "forever family".

### **Background on Foster Care and Consequent Adoptions**

The Child Welfare Information Gateway (2018) describes adoption as the social, emotional, and legal process of children becoming full and permanent legal members of another family when they will not be raised by their birth parents, while maintaining genetic and psychological connections to their birth family (Child Welfare Information Gateway, 2018). In 2017, 123,437 of American children in foster care were waiting to be adopted (U.S. Department of Health and Human Services, 2018). Of those children, 59,430 of them were successfully adopted into permanent families. Children waiting to be adopted spend an average of 30.9 months in foster care (U.S. Department of Health and Human Services, 2018). The legal systems that facilitate child welfare attempt to resolve cases in a timely fashion, but many children spend years in foster care without resolution or answers as to their permanency. While parents attempt

to overcome their problems, experience systemic delays, and often struggle to successfully navigate the process of having their children returned to them, these children sit waiting in foster care while lasting damage to their cognitive, social, emotional, and often physical functioning is building (Hughes, 2006). Twenty four percent of children exiting the foster care system do so because of their adoptions, and 51% of them are adopted by their foster parents (U.S. Department of Health and Human Services, 2018).

Common experiences for children adopted from foster care include abuse, neglect, and abandonment, which occur within the context of birth homes and possibly subsequent foster homes. The concept of child abuse that once encompassed physical and sexual assaults has now been expanded to include emotional, verbal, and spiritual attacks (Lewis, 1999). Both neglect and abuse are considered traumas of absence (Hughes, 2006). In neglectful and abusive homes, unrelated issues children face, such as physical impairments or illnesses are often ignored, contributing to harm done due to the absence of proper care (Purvis, Cross & Sunshine, 2007). Exposure to abuse and neglect leads to a predisposition to attachment issues, depression, anxiety, attention problems, learning disabilities, and other developmental, social, behavioral, and mental challenges (Purvis, et al., 2007). Neglect accounts for 62% of a child's removal from home and placement into foster care, with parental drug abuse, caretaker inability to cope, and physical abuse following as the next most common circumstances (U.S. Department of Health and Human Services, 2018).

The adoption and foster care systems differ in their relations to permanency, but both share the experience of the loss of a caregiver or caregivers, which is disruptive to a child's ability to maintain healthy attachment relationships. The foster care system exists to protect, nourish, and maintain the physical safety of children, but lacks attention to the psychological and

developmental needs of children and their mental health (Hughes, 2006). Often children in foster care balance their growing relationships with their new family with visits with their birth families. This visitation presents complexities and challenges that limit development in parent-child attachments (Bennett and Blome, 2013). Additionally, many children struggle emotionally due to not understanding their situation, which is the result of a system that lacks developmentally appropriate ways of communicating, educating, and empowering children (Hurwitz, 2003).

### **Background on Trauma**

Trauma experienced by children placed in foster care can be described as developmental trauma, which is a specific type of trauma referring to early life experiences with abuse and neglect by caregivers (Hughes, 2014). During traumatic events, all of the body's resources are channeled towards survival instead of other functioning areas. From neurological, physical, social, cognitive and emotional perspectives, the world is viewed as being threatening, and children will operate from this fear state because it ensures safety and security. When a child experiences trauma, the result is a regulatory system deficit. Stress interrupts short term memory functioning, and cognitive processes are challenged and distorted by the fear-based state (Forbes and Post, 2006). Abuse and neglect are traumatic experiences that inhibit the brain's functioning, and responses to these events often include dissociation and hyperarousal (Perry, 2005).

Children who lack the ability to consciously organize or verbally identify their memories will store their traumatic experiences on a somatosensory level, which includes sensations, behavioral representations, and nightmares. Trauma interferes with conscious recall, or declarative memory, but does not influence the level of implicit memory, emotional responsiveness, or sensorimotor sensation functioning (Klorer, 2017). For children who have

experienced abuse and neglect, their bodies will hold those memories to be felt and manifested on a nonverbal, physical level (Forbes and Post, 2006). Trauma survivors often report feelings of disconnection, disassociation, and detachment from their bodies (Dieterich-Hartwell, 2017).

Even after a threatening event ends, or a child is physically removed from traumatic situations, the brain, and the body experience long term consequences. The brain has already developed connections associating daily instances with the traumatic event that will trigger the child to developmentally, emotionally, and physically regress to their levels of functioning during the trauma (Perry, 2005).

### **Background on Attachment**

John Bowlby, known as the “father of attachment”, studied and conceptualized attachment and created the basis for modern understanding of attachment theory. Bowlby and developmental psychologist Mary Ainsworth mutually defined attachment as a deep and persistent emotional bond connecting one person to another (Ainsworth, 1973, Bowlby, 1969). It has since been described as an emotional parent/child tie that makes them important to one another (Levy, 1995). Dr. Daniel Hughes, a clinical psychologist specializing in trauma and attachment within the context of childhood abuse and neglect, understands it as a child’s readiness to seek out specific adults for mutual positive experiences, comfort, and safety (Hughes, 2006). Simply put, it can be interpreted as the interpersonal bond between a child and their caregiver (Purvis, et al., 2007). These relationships can be defined by three key characteristics: an enduring emotional connection to a specific person, cultivation of safety, comfort, and pleasure through the relationship, and distress provoked during actual or threatened separation (Perry, 2013).

Bowlby studied attachment as adaptive through an evolutionary lens that conceptualizes the safety of a caregiver as a survival mechanism (Bowlby, 1958). Bowlby determined that infants are biologically motivated to maintain proximity to primary caregivers in order to maintain safety (Bowlby, 1969, 1973, 1980). They utilize body-based behaviors, such as smiling and crying, to achieve this (Bowlby, 1969). The drive to feel security and protection develops attachment behaviors that consistently produce this result of proximity (Bowlby, 1969, 1973, 1980). Through these attachment behaviors, children maintain proximity to their caregivers, affirm their ability to survive, and feel protected as a result (Bowlby, 1969). Consistent disruption or absence of attachment between the primary caregiver and child will impact the emotional, social, and cognitive functioning of a child throughout their life (Bowlby, 1988). Attachment relationships influence future relationships by contributing to the development of internal working models, which are patterns of thinking about self, others, and the relationship between the two (Bowlby, 1969). These models determine one's perception of self, other, relationships and the world (Bowlby, 1969). When early-life relationship patterns are internalized in children, they determine factors of behavior throughout their lives (Bowlby, 1969).

For Bowlby, attachment was an all or nothing process (Bowlby, 1969), but through further studies of attachment, the concept of different attachment security styles came about (Ainsworth and Bell, 1970). Mary Ainsworth conducted multiple studies using a research procedure known as the Strange Situation, to explore the unique characteristics of different children's attachments that made them secure or insecure. She observed attachment between mothers and infants and identified three main attachment styles; secure, insecure avoidant, and insecure resistant/ambivalent (Ainsworth, 1978). Upon further investigation into attachment

theory, a fourth attachment style was contributed to the field, known as disorganized (Main and Solomon, 1990).

With a secure attachment, a caregiver consistently responds to a child by providing affective presence, sensitivity, and availability (Hughes, 2006). The securely-attached child knows he can depend on his caregiver, and therefore is free to explore independently, but is still comforted and happy when they are reunited. Children with insecure attachments present a variety of different responses to their mothers, including avoidance or rejection of engagement, hesitance to explore, resentfulness, and minimal reaction to her absence. (Ainsworth, 1978). Disorganized attachments develop in children who present both avoidant and resistant behaviors, often in confusing and anxiety provoking relationships (Main and Solomon, 1986).

Attachment is evaluated and observed through specific behaviors of children, such as seeking proximity and looking for comfort when in distress (Bowlby, 1969). Much of attachment research highlights the psychobiological influences on communication between parents and children (Malchiodi and Crenshaw, 2014). Attachment theory aids clinicians in understanding behavior patterns, relational dynamics, and developmental implications of abuse and neglect with children in the child welfare system (Bennett and Blome, 2013). Theories of attachment rely on the notion that relational and individual experiences in childhood have a lasting impact on that person's mental health, emotional regulation, and future relationships (Bettman and Friedman, 2013). Separation, loss, abuse, neglect, or other trauma result in attachment relationships, which are meant to provide safety, regulation, and security, becoming sources of dysregulation, instability, and fear (Renschler, T., Lieberman, A., Hernandez Dimmler, M., & Burke Harris, N., 2013).

Those with secure attachments are comfortable and competent in close relationships. They have a healthy desire to take on qualities of their parents and make them proud, and can integrate intimacy with others and independence, balancing the interests and preferences of their family with their own individuality. In a home where adults are in charge and consistent, children are able to trust others, respect boundaries, develop social skills, and be equipped for growth and love in the future (Purvis, et al., 2007).

The ability to reflect on and regulate emotional states is also supported by healthy attachment. With parental support, changes between emotional states become easier and more gradual, often occurring through attunement of affective states. When parents respond to their child's needs, they are supporting them in learning affect regulation, and through co-regulating with caregivers, children eventually learn how to regulate on their own. Infants experience affective states without meaning, but with a parent's responses, they become able to identify states and organize their understanding of self, caregivers, and the world (Hughes, 2006).

The growth and maintenance of healthy relationships are necessary for people to function in society, learn, develop, work, love, and survive. Basic attachment capacities enable optimal brain development and healthy relationship building, and foster empathy, concern for others, and cooperation. A healthy attachment with a primary caregiver can predict healthy future relationships (Perry, 2013). Once a child learns how to form a secure attachment, they will not forget, and they will be able to form healthy relationships from that point forward (Hughes, 2006).

### **Developing Attachment: Moving Through the Body**

The brain begins its development of neurological pathways relating to learning and social connections during the first moments between a mother and child. Through responsiveness to needs and physical touch, babies learn to process sights, sounds, sensations, and interactions. The

most important factors in attachment are the qualities of interactions that exist on embodied, affective, and multisensory levels (Levy, 1995; Tortora, 2013) Touch through cuddling, holding, and kissing causes neurochemical activities in the brain that contribute to the organization of brain systems that foster attachment (Perry, 2013). Posture, vocal tone, gestures, and facial expressions also contribute to the quality of these exchanges (Bowlby, 1969). Activation of the senses, shared nonverbal experiences, emotional synchrony, affective attunement, joint attention, and responsive caregiving all help to develop preverbal body memories and build secure attachment (Purvis, et al., 2007; Klorer, 2017; Tortora, 2013).

Nonverbal interactions are the core contribution to emotional connections and communications (Tortora, 2013). As infants and parents interact, they discover each other and themselves in relation to one another. By studying their impact on a caregiver through eye contact, facial expression, vocal qualities, gestures, and physical touch, infants discover themselves and develop self-agency. Similarly, when a parent recognizes their babies' responses to them, they build their parental identity (Hughes, 2006).

Patterns of interaction develop attachment, in addition to the expectations gained of how adults provide the child with comfort and protection (Levy, 1995). Nonverbal interactions are created mutually by both the parent and infant, and they both organize the experience into mental representations that serve the relationship's development (Bowlby, 1969). From the first moments of nonverbal connection after birth forward, matching and mismatching behaviors regarding vocalizations, eye contact, movement, posture, and feeding and sleeping schedules begin to develop nonverbal patterns and relationships (Purvis, et al., 2007). Through the rhythms of life and creating shared meaning of nonverbal experiences, parents, and children develop a dance of connection (Hughes, 2006). As a child learns what behaviors of their own elicit positive behaviors from caregivers, they develop expectations of these exchanges and their associated feelings of love, worthiness, or the opposite (Bowlby, 1969). By developing reliable, organized

expressions, deep emotional states can be shared and mutually understood. Throughout the process of building attachment, babies learn to rely on trusted adults, based on their confidence that their needs will be met (Purvis, et al., 2007).

The cycle of caregiving begins with the child's needs and behavior. Infants express their emotional and physiological states and needs through nonverbal communication. Upon recognition of the child's nonverbal expression, the caregiver has cognitive and emotional responses to it. These responses determine the caregiver's behavior, which conveys messages to the child, influencing their feelings on self and other, levels of trust, and their development (Hughes, 2006; Schofield and Beek, 2014). A parent's consistent responses to their child's nonverbal cues help them feel understood, seen and nurtured through the reliable meeting of their needs (Tortora, 2013). This consistency, when sensitively recognizing and meeting a child's affective states and needs, and attuned nonverbal interactions facilitate this natural relational progression (Hughes, 2006). When a baby's needs are met, anxiety decreases and security and trust that allow for freedom to explore is cultivated. Nonverbally communicating availability through responsiveness helps children feel trust in their caregivers, making this essential for a healthy attachment. Over time, these behaviors become more organized and create mutual delight between dyads (Schofield and Beek, 2014).

One of the foundational elements of attachment is physical safety, and for young children, this is the functional purpose of developing an attachment relationship. The mind functions optimally once safety is achieved, and this allows exploration and growth in other areas of development to occur. Without the feeling of safety, the mind preoccupies itself with creating it and reducing threats. When a parent responds to a child's cues and meets their needs, they support their feelings of safety, facilitating freedom to explore and grow (Hughes, 2006).

In healthily functioning families, the process of building a secure attachment between a parent and child is natural (Hughes, 2006). A secure base is the core of this family environment.

A secure base is created through loving relationships with reliable and protective caregivers, and a base from which a child can explore the world around them and rely on returning to (Schofield and Beek, 2014). The human brain processes relationships through three neurobiological systems: attachment (looking to another person for safety), companionship (enjoyable intersubjective experiences), and dominance (accepting leadership and guidance in pursuit of a goal). With a securely attached child, these systems integratively function, and the parent provides safe care, enjoyable shared experiences, and boundaries consistently. Nonverbal interactions are the core of an attachment relationship and all relational functioning, and all attachments, secure or not, are developed through body-level experiences (Hughes, 2006).

### **The Impact of Poor Attachments and Traumatic Experiences**

Adopted children who have a history of psychological trauma from abuse, neglect, and loss have difficulty forming new attachments, and long-lasting psychological trauma can make trusting new adults challenging (Harvey, 2003a). Histories of abuse, neglect, and multiple foster care placements leave children with attachment disorders and developmental trauma. When a child is abused or neglected, the natural desire to form a secure attachment with a caregiver is lost (Hughes, 2006). Deep down, these children long for connections, but, because of their upbringing, lack the understanding of how to make them (Purvis, et al., 2007). Abused and neglected children are less likely to look to caregivers for safety, comfort, and learning about self, others, and the world (Hughes, 2006). A child placed in multiple foster homes deals with the heavy impact of these challenges over and over again (Hurwitz, 2003). When a child receives mixed messages about their abuse and abuser, which often happens with inconsistently involved birth families, hope is kept alive, and this blocks the formation of new attachments (Klorer, 2017). Many children lack a way to express, understand or process trauma that they experience, and without intervention, the body/mind system will hold these unprocessed and unexpressed

experiences. Without another outlet for these embodied feelings and memories, external behaviors will remain the primary mode of communication (Forbes and Post, 2006).

When attachment is absent in a child's life, behavioral and cognitive functioning will be negatively impacted (Klorer, 2017). Deprivation of needs, physical harm, or emotional harm can halt potential for a secure attachment. When a child experiences developmental trauma, they are at risk for impairments in seven core domains of functioning: attachment, biology, affect regulation, dissociation, behavior control, cognition, and self-concept (Hughes, 2006). These children often present with sensory processing issues and aversions, motor skill and growth impairments, inappropriate relational styles, neurochemical imbalances, problems with transitions, attachment disorders, social deficits, and delayed learning, because their brains were deprived of the sensory information that is necessary to form pathways that enable competence in these areas (Purvis, et al., 2007). Cognitive development of sensory integration, language, reasoning, problem-solving, academic skills, and the ability to reflect is also impaired (Hughes, 2006). Even after living in nurturing, healthy homes for many years, children who experienced early deprivation and developmental disruptions can still have suboptimal brain chemistry, which impacts their abilities to understand, regulate, and consciously control their thoughts, feelings, and behaviors (Purvis, et al., 2007).

When trauma exists within the context of family relationships, individuals are subjected to various symptoms of mental illness. Children with disorganized attachments are at risk for mental health issues that are expressed both externally (ADHD, explosive outbursts, etc.), and internally (depression, mood disorders) (Hughes, 2006). Common issues include grief, attachment disorders, cognitive dysfunction, anxiety, depression, and feelings of fear, shame, and

stress (Purvis, et al., 2007). Disorganized attachment can cause affect dysregulation, dissociative behaviors, inability to reflect, impulsiveness, and self-image issues (Hughes, 2006).

Children with attachment problems may reject care and interactions, struggle to enjoy intersubjective experiences, and have negative expectations of themselves and others. Avoidance of relational experiences can offer protection from feeling shame, fear, or failure. They often lack a history of fun and joyful experiences, and they have little tolerance for participating in or watching others have them. When others are enjoying experiences together, they may exclude themselves, or try to stop it (Hughes, 2006).

A child who has experienced trauma is a child who is scared of their existence becoming threatened and lives in survival mode to ensure they are protected. These fearful emotions and memories manifest into the child's behavioral patterns. Children of abuse and neglect are satisfied by independence and a sense of power and control. For many children, angry behaviors are the expression of frightened emotions. Vulnerable states such as being praised, asking for help, fear, and sadness are avoided due to lack of safety, and are often disguised as anger, which can offer a sense of protection (Hughes, 2006; Forbes and Post, 2006). The lack of a secure base produces anxiousness, mistrust of others, defensiveness, assertiveness, and over controlling tendencies (Schofield and Beek, 2014). Children may be passive or overly compliant, due to their understanding that they are vulnerable to the influence of adults, and that the trauma in their lives is unpredictable and uncontrollable (Levy, 1995). Behavioral patterns will develop to protect against separation, abuse, and neglect. If a child has to manage a caregiver that is a source of fear in their lives, regulating feelings, trust, and behavior will be challenging (Schofield and Beek, 2014).

Trauma that involves the intrusion of personal space and one's body can impair a child's understanding of boundaries within the self/other relationship and their own personal autonomy. This can result in rigid boundaries that lead to isolation, or too fluid boundaries that make children vulnerable to further physical or emotional intrusions later in life (Lewis, 1999).

Developmental trauma dysregulates the affective sense of self, and the abilities to identify, regulate, and express emotional states become impaired; children experiencing it cannot focus on their emotions, thoughts, or behaviors. As a result, staying present and engaged and managing behaviors are difficult. The resulting disorganized attachments can prevent children from being able to rely on others to help them manage their emotions. The ability to attend to physiological states such as hunger, pain, arousal, and sleep also becomes dysregulated (Hughes, 2006).

Children who have challenging upbringings and experience adults as untrustworthy may have low self-esteem, and experience themselves as worthless, bad, and dangerous. The deep separations they have experienced can lead to doubts about their goodness and worthiness of receiving love. They are often trapped in a mindset of failure and rejection, and continue behaviors that affirm this outcome (Hughes, 2006; Schofield and Beek, 2014). In their state of vulnerability, they will use any means necessary to protect themselves. These children feel impulses to recreate their past experiences by acting out and bringing out strong emotions in their caregivers to reaffirm their protective feelings of shame and a negative self-concept. This creates an illusion that the lack of care is their fault and not the fault of their caregiver, and feeling responsible for the events of their life provides a sense of control that limits vulnerability. By blaming themselves, children develop a negative view of themselves that manifests in their actions and expressions (Hughes, 2006). The shame and concept of a bad self teaches the child

that they are unworthy of care and that no adult could continuously love them, so there is no point in trying. This ends the relationship on the child's terms before it ends otherwise on the adult's (Hughes, 2006). Children who experience early childhood trauma may develop negative expectations and beliefs regarding themselves and adults. These internal systems will transfer into new relationships, and environments (Schofield and Beek, 2014).

Size and ability level make children helpless in the world, and they are dependent on adults for fulfilling their basic needs. When a child cannot depend on adults to do this, they feel overwhelmed, scared, and unsafe (Hurwitz, 2003). Inconsistent levels of care at home will lead to the perception that adults are unreliable (Purvis, et al., 2007). When a caregiver is unpredictable in meeting needs, there is damage to the sense of self, cognitive functioning, and the capacity to develop healthy relationships (Hurwitz, 2003). Aggressive lashing out, irritability, and destructive, perfectionist, or over-controlling behaviors may be compensations for feelings of weakness. Children who do not experience a reliable caregiver may hoard objects or food, struggle with regulation, be hypervigilant or aggressive, and have extreme tantrums (Hurwitz, 2003). The needs of food, physical safety, and objects overshadow the buried needs for comfort and support. Children begin to believe they are the only ones who can meet their needs, and stop relying on others (Hughes, 2006).

Children who come from difficult backgrounds have little experience with their thoughts and feelings being acknowledged and understood. Without this kind of caregiver support in managing emotions, children develop coping mechanisms that are often aggressive or dangerous (Schofield and Beek, 2014). Harmed children will act out (yelling, biting, spitting, hitting, lying, etc.) or act in (hide, become unresponsive or depressed, withdraw, etc.) or exhibit behaviors of both. At risk children often fight, isolate, and manipulate as a result of their feeling of being

alone against the world. They will seek any attention available by acting out (Purvis, et al., 2007).

Children who are in foster care or adopted often feel senses of shame, silence, and secrecy regarding the events of their lives. Information about the circumstances of their removal and biological families are commonly kept hidden or explained in ways that cannot be developmentally understood (Stepakoff, 2003). Children who experience loss of a caregiver may feel conflicts of loyalty about their sense of family (Hussey and Layman, 2003). Some children may feel they are betraying their birth parents by loving new caregivers (Klorer, 2017).

For children with difficult backgrounds, the ability to form healthy relationships is overpowered by memories of powerlessness, fear, and separation (Levy, 1995). The detachment that occurs when children fear abandonment hides their need for love and can block new relationships from developing. These children will move towards families that can fulfill their needs, but also push them away because attachment to, and reliance on, others are frightening (Klorer, 2017). Infants, toddlers, and children with developmental trauma cannot initiate or maintain pleasurable states in isolation. They achieve these positive states through intersubjective interactions. When a child cannot trust their caregiver, the capacity to participate in reciprocal relationships and view themselves positively is destroyed. Without healing, these children may never secure themselves in relationships with others or with society (Hughes, 2006).

If a child's first foster care placement fails, it reaffirms the messages from their original caregivers that they are worthless, bad, and undeserving of the effort to care for. Multiple foster care placements create a barrier to developing safety, consistency, and secure attachment relationships (Hughes, 2006).

Children from difficult backgrounds have limited experiences and understanding of life and the roles, rules, and expectations the world operates on. The primitive brain monitors survival needs, and when it is threatened and becomes active, other brain areas shut down, and the primary task is functioning aimed towards survival. Children develop unhealthy survival strategies that must be unlearned. Manipulation in new relationships is a survival skill of abused and neglected children that often frustrates, shames, and overwhelms foster parents. Creating conflict among adults becomes enjoyable. These children often feel little remorse or guilt after physically or emotionally harming others. While securely attached children view adults as people with feelings and whom they feel empathy towards, insecurely attached children perceive adults as objects giving them what they want (Hughes, 2006).

### **The Larger Societal Impact of Early Trauma and Poor Attachment**

All of these consequences of childhood abuse, neglect, trauma, and poor attachment histories have significant impacts on the child, and their future development, sense of self, relationships, health, behavior, and role in society. Addressing these problems is not only critical for adopted children and their families, but for the communities who experience the repercussions on a societal level. Poor parental attachment is significantly linked to juvenile delinquency, and targeting attachment in treatment may prevent future delinquent behavior (Hoeve, M., Stams, G. J., van der Put, C. E., Dubas, J. S., van der Laan, P. H., & Gerris, J. R., 2012). Negative behaviors of parenting including rejection, neglect, and hostility, as well as parenting style attributes, including attachment, can also be associated with delinquency (Hoeve, M., Dubas, J., Eichelsheim, V., Laan, V., Smeenk, W., & Gerris, J., 2009). Additionally, childhood abuse may be a risk factor for alcohol-related disorders and problems in adulthood, when survivors become dependent on alcohol for coping, self-medicating, gaining control, and

combating feelings of isolation (Spatz Widom & Hiller-Sturmhöfel, 2001). Childhood abuse and neglect are connected to antisocial behaviors including committing crimes and engaging in violence. Maltreatment in childhood contributes to a cyclical pattern of violence, where children who have experienced violence will perpetuate it in their future relationships and behaviors (Herrenkohl, Jung, Lee & Hyun-Kim, 2017).

Childhood trauma impairs the ability to make healthy decisions and evaluate risk. Survivors may struggle to learn from mistakes, and cyclically make poor decisions. Without risk assessment skills, children who experience trauma may grow up to make choices that are detrimental to themselves and others. These adults impose a significant cost on society, which must develop systems for coping with their burdens (Birn, Roeber & Pollack, 2017).

Posttraumatic symptoms and behaviors impact legal and behavioral challenges that involve youth with the criminal justice system. Instead of learning from past experiences, these individual's brains are preoccupied with survival due to their trauma reactions. At least 75% of youth involved in the juvenile justice system have experienced traumatic victimization. This focus on survival leads youth to employ desperate measures to cope with perceived threats. Anger, anxiety, social isolation, aggressiveness, impulsivity, self-destruction, and an inability to abide by rules and laws will result (Trauma Among Youth in the Juvenile Justice System, 2016).

### **Caregiver Challenges in Building Attachment**

Parenting children with developmental trauma and attachment challenges requires self-control, empathy, and emotional regulation. When a child inconsistently makes progress, caregivers often feel frustrated that it is not maintained. Parents are often led to question the child's investment in the relationship, which leads to them questioning their own. Adoptive parents may receive their child's withdrawal, aggression, defiance, and rejection as evidence of

their poor parenting abilities. This sense of failure makes them feel unsafe with the child, and that their worth is inconsistent. They may become withdrawn and angry towards the child, limiting intersubjective experiences. Lack of direct validation prevents caring for the child from being a pleasurable experience, and it becomes hard to consistently, deeply commit to caring for the child. Parents who frequently express anger, fear and rejection towards a child will cause the child to avoid these shame-inducing intersubjective experiences due to the lack of safety they feel. The inconsistent and negative sense of self that develops from this pattern prevents the child from leaning on the parent for further learning (Hughes, 2006).

The relationship can become frustrating when a child's long-term psychological trauma makes it difficult to trust new adults (Harvey, 2003a). Foster and adoptive families must commit to patience as a child's beliefs about self, other, and relationships change within their changing environments (Schofield and Beek, 2014). The extreme behaviors children of trauma present, such as lying, stealing, and aggression can also result in parental loss of hope (Harvey, 2003a).

### **Treating Attachment Problems**

Children in adoptive and foster families can still develop attachments as long as they receive care that is sensitive to both of their needs (Schofield and Beek, 2014). When treating attachment problems, the parent should be present in therapy. Working with parents in treatment helps the child differentiate from birth parents, translates therapeutic experiences into daily life, provides psychological safety, and gives the parent necessary support. Without proper education, support, and interventions for troubled children, caring for them becomes emotionally taxing in a way that prevents healthy family relationships from forming (Hughes, 2006).

For caregivers, finding resolution in one's attachment history and relationships must occur to support a child in doing the same. The attachment history of parents is critical to explore

because a child with attachment, behavioral, and emotional problems can activate and highlight aspects of the caregiver's past relationships or childhood that are unresolved or disorganized.

Integration, understanding, and resolution of these histories help caregivers provide better care to their children (Hughes, 2006). A caregiver's sense of hope and well-being must be addressed, because their mood, attachment styles, regulation, and social skills can be passed down.

Someone who is preoccupied with their own problems cannot commit to healing a child's (Purvis, et al., 2007).

Interventions should be sensitive to the symbolic and thematic representations of trauma children develop, rather than the factual information surrounding it (Klorer, 2017). Healthy resolution of problems involves treating the whole child, not isolated behaviors or symptoms. To do this, clinicians and caregivers must address fear responses, establish clear and sensitive authority, provide sensory stimulation, teach and model social skills, support healthy body chemistry, encourage emotional connections and develop strong bonds (Purvis, et al., 2007).

Through therapy, a child with attachment challenges can be expressive, share vulnerable guilt for problems in their placements, access feelings of sadness or loneliness, and learn to look to caregivers for safety and stability (Hughes, 2006). Attachment-focused therapy must prioritize re-creating early relational experiences that may have been absent or disrupted. This process emphasizes emotional regulation, stress reduction, and the development of safety and security (Malchiodi and Crenshaw, 2014). Before a child can relationally connect to others and the world, they must first connect with their own feelings, needs, emotions, pains, and fears (Purvis, et al., 2007). Goals in current attachment treatment models include increasing sensitivity, meeting the child's needs, understanding attachment needs and cues, developing empathic connections, and understanding how the child views themselves and others (Bennett and Blome, 2013).

## **Goals of Treatment**

### **Trust and safety.**

When one's first attachment is disrupted, the primary goal of treatment in psychotherapy is to build trust with the caregiver (Hughes, 2006). Similarly, when working with clients post trauma, the job of the therapist is to facilitate a safe environment to organize, regulate, and express one's experiences (Klorer, 2017). Safety opens the door for learning and positive reciprocal interactions. Adopted children or those in foster care require specialized care that emphasizes this safety so that trust can be built (Hughes, 2006). Trust and safety are created in a therapeutic environment through boundaries, predictability, rules, and a set time and place (Klorer, 2017). Caregivers maintaining proximity physically symbolizes safety and offers the caregiver as a source of meaning and affect regulation. Feelings of safety come from trusting an adult to provide comfort, support, and the needs necessary for development (Hughes, 2006)

### **Messages of reliability, responsiveness, and availability.**

Optimal attachment requires caregivers who can remain sensitive and available even when dealing with hostility and lack of trust with their child (Beek and Schofield 2014). When a child knows they have this kind of caregiver, they are confident their needs will be met and feel an increased level of safety as a result (Hurwitz 2003). Caregivers must implicitly and explicitly express their availability, sensitivity to needs, and reliability. By doing this, they support their child in learning to trust them and others. Teaching children that their needs will be met whether they are with or apart from their caregiver reduces anxiety and increases confidence and abilities to explore (Schofield and Beek, 2014). Caregivers must also remain mindful and understanding of the child's learned survival strategies. When a child is expressing needs through these behaviors, that are often difficult to understand, caregivers need to respect, honor and respond to those needs (Purvis, et al., 2007).

Therapy can support this experience within the parent/child relationship by helping caregivers become alert to a child's signals and cues for their needs. Learning how to send verbal and nonverbal messages of availability can help develop this trust. Therapy also must help the child become aware of and process their caregiver's signal, re-affirming their availability and reliability. A parent's sensitivity helps children learn to regulate their own feelings, which eventually aids in regulating behavior. Therapeutic experiences that practice thinking about a child's inner experience flexibly and reflecting it back to them help children develop the ability to think about their feelings, thoughts, and ideas, as well as those of others (Schofield and Beek, 2014).

**Mutual positive experiences, unconditional love, acceptance and belonging.**

Genuine positive connections must be developed to support healthy attachment among parent/child dyads (Klorer, 2017). Positive emotional states increase the motivation to continue developing close intimacy and help further build attachment, while shared positive experiences facilitate trust and learning (Harvey, 2003a; Purvis, et al., 2007).

Attachment relies on a caregiver's full acceptance of the child and the range of their needs and expressions. Regardless of conflicts that occur, unconditional acceptance affirms a child's sense of safety and permanence in the relationship. Therapy can support caregivers in providing unconditional love and acceptance, and aid children in understanding and welcoming these feelings from adults. Conflicts can lead vulnerable children to return to patterns of mistrust, and caregivers must utilize these opportunities to communicate unconditional love and acceptance (Hughes, 2006). Attachment-based care focuses on unconditional valuing of a child, which is essential because performance-based praise can be removed or absent (Hughes, 2006; Purvis, et al., 2007). Commitment from new caregivers can be expressed through affirmations of love, the relationship, and the child's worth. When there is a conflict, mismatch, or brief separation that is challenging, therapy can support caregivers in their ability to initiate repair and communicate that the relationship is more important than any problem. Explicit unconditional

acceptance of both strengths and challenges increases children's self-esteem, and is especially important when a child is struggling to express themselves. There is trust that even during challenging circumstances, the child's needs will be met, and that limits, restrictions, and boundaries are set out of love for the purpose of safety (Hughes, 2006).

With feelings of worth, love, and support, this growing self-esteem helps children be resilient when facing adversity. Caregivers must be mindful of this need for acceptance and unconditionally accept themselves first before they can fully give this to a child. Therapy gives opportunities for caregivers to model their personal acceptance of strengths and difficulties to help achieve the same in their child. Promoting activities that affirm ability, success, and positive feelings can help children develop this. Attachment oriented therapy allows parents and children to practice interacting under circumstances of unconditional acceptance, and provide them with tools to continue this bond at home (Schofield and Beek, 2014).

Healthy emotional and psychosocial development depends on a child's ability to feel that they belong. The anchorage of an unconditional family membership provides a secure base for children to explore, and develop a personal identity. This is achieved by including adoptive children as full members of the family, while maintaining a connection to the birth family. Verbal and nonverbal messages about relations to both families help a child create their identity and role, and be reflective about their needs and feelings about family membership. This creates a sense of connection, and attachment-focused therapy will help a child navigate their feelings of belonging and personal identity concerning their families (Schofield and Beek, 2014).

### **Emotional regulation, awareness, and expression.**

When caring for children with disrupted childhoods and attachments, caregivers must help rebuild key social skills by relating to their child, co-regulating, and encouraging and modeling reflective functioning (Hughes, 2006). Caregivers must help children identify, validate,

and process their feelings (Purvis, et al., 2007). By aiding children in regulating strong emotions, matching affective communications, and coaching and modeling desired behaviors, parents support them in learning adaptive behaviors (Hughes, 2006). Children who experience trauma need to learn to communicate their needs and feelings in order to experience empathy, equality, and intimacy with others. Healing occurs through empowering children to reclaim their voice and space in the world (Levy, 1995). In helping children understand and express their emotions, they develop the ability to regulate, have empathy, and use the pro-social behaviors that are necessary for relationship building (Schofield and Beek, 2014).

**Social skills, boundaries and management of self and other.**

Normal boundaries of self and other must be addressed after they are ignored when the body is invaded through abuse or neglect (Levy, 1995). Children from difficult backgrounds may have unique fears and boundaries regarding touch (Cross, Purvis, and Sunshine 2007). Allowing children to control touch and boundaries in home and in therapy can help in affirming their safety (Klorer, 2017). Developing a healthy cooperative relationship includes compromise, asking for help, feelings of competence, and developing autonomy while working together. Children from difficult backgrounds may lack this experience, having grown up either without having any choices available to them or making too many on their own without parental support and input. Stressed households lack opportunities for fun, mutually enjoyable activities, and children may not see themselves as impactful or competent, and also may not see adults as partners. By affirming competence, offering choices, and maintaining safe boundaries, caregivers can help develop this cooperative relationship (Schofield and Beek, 2014).

### **Expressive Therapies**

Talk therapy is the least effective therapy for young children struggling with attachment disorders and sensory processing delays (Purvis, Cross & Sunshine, 2007). Talk therapy highlights the attachment they lack through their inability to consciously process, reflect upon, and express their inner experiences. Thoughts and feelings exist outside of verbal repertoires, and when they are not accessible through conversation, more expressive modalities must be employed (Malchiodi and Crenshaw, 2014). Talk therapy also lacks the sensory experiences that are supportive of attachment development (Purvis, et al., 2007). While children lack the verbal skills to express themselves through language, their behavior provides information that can be used to understand their experiences (Klorer, 2017). A child communicates through nonverbal messages that must be investigated. Interventions that involve and integrate a child's ability to talk, move, touch, watch and interact give them an active role in the therapeutic process that will better aid them in embodying and sustaining the work being done. Physical activities that utilize an active, hands-on approach are the best-suited communication methods for young children, and those with traumatic backgrounds (Purvis, et al., 2007). Expressive activities allow them to be present, equal participants in the therapeutic process (Harvey, 2003a). Participants are empowered to experiment with new roles and behaviors in a safe environment (Johnson and Lubin, 2003). These modalities provide an opportunity to actively practice behaviors themselves rather than talking about them, and provide clarity regarding roles and relationships for the therapist (Wiener and Oxford, 2003).

While talk therapy draws attention to verbal communication, expressive methods provide an embodied way to address behaviors, relationships, and patterns. They challenge language based defense mechanisms and engage clients that may best learn and process information that is

presented kinesthetically or visually (Winer and Oxford, 2003). Worries, family dynamics, and history are concealable when talking is the primary form of communication, but through more active methods, these internal experiences can be externalized. When expressive therapies are used, individuals are not limited by verbal or intellectual abilities that are underdeveloped due to age, diagnosis, or education (Wiener and Oxford, 2003). Some family issues such as attachment, loss, trauma, separation can be resistant to using verbal approaches, but expressive modalities allow children to be active participants in therapy, promote healing through interaction, and provide shared positive experiences (Harvey, 2003).

To family outsiders like a therapist, concerns, patterns, and history are concealable. Expressive therapies transition these internal elements into physicalized, concrete externalized expressions. By doing this, therapists support access to observing, addressing, and resolving these inner conflicts (Johnson and Lubin, 2003). Challenging the secrecy often accompanying foster care and adoption can involve a concrete sense of self and one's life narrative. The creative arts support this sense of self-agency. Physical action helps us take in the meaning and messages of our stories more deeply (Stepakoff, 2003).

Creative arts therapies apply music, drama, dance/movement, fine and visual arts to psychotherapeutic frameworks (Malchiodi and Crenshaw, 2014). They utilize expressive activities to facilitate therapeutic experiences, engage the body, and address the memories by making them accessible (Klorer, 2017). These modalities help children tell stories they cannot tell with words (Kaiser, 2003), and by utilizing less direct forms of communication, therapy is less threatening and more accessible for children (Hurwitz, 2003). These active approaches aid clients in multisensory engagement that fosters self-exploration, socialization, developmental progress, and emotional expression, awareness, and regulation (Malchiodi and Crenshaw, 2014).

Creativity is channeled both into the art form and towards the discovery of new insights, problem resolution, and coping mechanisms (Martinec, 2018).

Additionally, engaging in creative activities can activate physiological relaxation responses, decreasing emotional barriers to therapeutic processes, such as anxiety and fear (Malchiodi and Crenshaw, 2014). Through access to self-soothing, creative arts therapies reinforce feelings of safety and allow resilience and behavioral mastery to be built by practicing skills and developing strengths (Malchiodi and Crenshaw, 2014; Klorer, 2017). Artistic interventions reinforce links between choices and outcomes, and this understanding of consequences can be utilized to modify behavior in the outside world (Betts, 2003).

Creative arts therapies provide a healthy sense of control, adaptive coping skills, self-expression, symbolic communication, increased self-awareness, improved self-concept, and an opportunity for needs to be nurtured and met (Hurwitz, 2003, Klorer, 2017, Betts 2003, Hinz 2003). For children involved in foster care or adoption situations, they can aid in identity formation, combating a lost sense of self, and increase a child's self-acceptance. These modalities tap into unconscious processes relating to attachment security, that may be manifesting in a child's symptoms or behaviors (Betts, 2003). Creative arts therapists have achieved success utilizing these modalities with trauma survivors. Words are limiting with these clients, and through nonverbal communication, kinesthetic experiences, and multisensory processing, creative arts therapies can be employed to treat this population (Malchiodi, 2015).

In creative arts therapies, opportunities for expression, exploring emotions, and modifying thoughts and moods are created, and conflicts are expressed with a lower sense of defenses. These strength-based modalities empower children to work through challenges and

follow structures in a non-confrontational way while reducing anxiety, increasing feelings of hope, and developing a sense of self-worth (Hussey and Layman, 2003).

Play therapy is another popular modality utilized with children, and opportunities for play through artistic modalities are created within creative arts therapies. Mutual play is effective because it generates shared creativity, imagination, and deeper meanings which allows intimacy, affirmation, and attachment to develop (Harvey, 2003). Improvisational play and artistic creation can be extended to create meaningful metaphors and themes that identify and explore emotional conflicts. Through these interactions, responsiveness, shared mutual attention, and re-establishment of positive feelings can be generated (Harvey, 2003a).

### **Dance/Movement Therapy**

The most common creative arts therapy modality utilized in attachment work is dance/movement therapy (DMT), because of its direct focus on the body (Malchiodi and Crenshaw, 2014). DMT is a form of psychotherapy that utilizes movement to improve emotional, social, cognitive, and physical functioning and integration. It relies on the understanding of the mind/body connection, and the assumption that external changes provoke internal changes, and vice versa. Movement is the core language utilized by dance/movement therapists, and the primary mechanism for change, and is the vehicle for identifying diagnoses and creating treatment plans and interventions for client interaction (Devereaux, 2008; Fried & Leventhal, 1995; Kestenberg, 1999; Levy 1988; Loman, 2016; Martinec, 2018 Tortora, 2006, 2010, 2013). Explorations involving external elements of the body, movement qualities, and spatial dynamics physicalize internal components of one's experience (Betty, 2013). The body is utilized to develop transformation, healing, relationships, and empathy. Through an integrative combination of creative expression and psychological theory, dance/movement therapists observe, evaluate,

and treat clients (Kestenberg, 1999). DMT connects physical and metaphorical processes to identify and address issues (Devereaux, 2014), and through the simultaneous active and metaphorical explorations of self and others, deeper understanding can occur (Devereaux, 2008).

DMT is an effective modality because of the role of the body and movement in each person's physical, social, cognitive, and emotional functioning. All aspects of human experiences, including emotions, memories, thoughts, and behaviors are constructed of kinesthetic elements related to the body (Levy, 1995). Nonverbal interactions communicate emotions, thoughts, and sensations and integrate one's inner experience with their physical experience (Tortora, 2013). Both physical and emotional sensations influence an individual's patterns of holding and movement throughout their life (Kestenberg, 1999), and through DMT, one can deepen the understanding of, and connections between, their bodily felt states, emotional experiences, and mental ideas (Tortora, 2013).

### **Dance/Movement Therapy and Children**

DMT is an ideal modality when treating children because the body is their primary tool for coping and communication (Levy, 1995). Movement is a language understood and utilized by children (Loman, 1998). Through the body, brain chemistry is regulated, and children can then learn, organize, and approach information more easily. Children best process information that is physically engaging and presented through active learning, which supports the therapeutic process (Purvis, et al., 2007). With movement as an instrument for communication, children can express themselves within the world they live in, rather than a more complex and intellectually challenging verbal world of adults (Kaban, 2003). Movement is a universal language that is mutually spoken among parents and children and facilitates secure attachments and effective communication (Devereaux, 2014). Parent-child movement therapy highlights the expressive

power of nonverbal communications (Kestenberg, 1999). DMT helps parents gain awareness and understanding of these communications and their child's responses (Levy, 1995).

DMT can help children transition inappropriate behaviors into appropriate ones without ignoring or rejecting the needs they express through their behavior (Loman, 2016). DMT offers the potential for increasing a child's range of coping mechanisms, through the expansion of movement repertoire that helps them access bodily resources that can be translated to emotional challenges. By introducing varied movement choices, children can develop the capacity for varied behavioral and relational choices, promoting increased adaptability and coping skills (Loman, 1998). As an active modality, DMT offers children a physical release of energy that can help combat aggressive behaviors. By exploring impulse control, boundaries, and expression of high-intensity emotions, children can healthily discharge their feelings while learning how to control and regulate themselves (Kaban, 2003). In a framework for supporting emotional regulation in maltreated children, DMT's use of the body is highlighted as being valuable for both children and caregivers, by providing tools for embodying, teaching, and experiencing regulation through the development of safety, emotional awareness, internal emotional coping, and management of external expressions (Betty, 2013).

The Kestenberg Movement Profile (KMP), is a movement analysis system used by many dance/movement therapists that connects movement patterns to phases of child development (Kestenberg, 1999). KMP assessment tools and techniques can help parents and clinicians use nonverbal expressions to communicate presence, contain boundaries through safety, and provide healthy outlets for externalizing internal experiences. Through the use of KMP vocabulary and rhythms, dance/movement therapists can identify differences between parent/child movement patterns and can help dyads achieve mutually satisfying patterns that facilitate shared

experiences and understanding. The KMP's focus on attunement can support adoptive families who lack familiarity with their child's fetal movement by supporting early communication and helping caregivers understand how to identify and respond to their child's needs (Loman, 2016). The KMP's integration of developmental phases is effective when working with children who experience disrupted development because it offers interventions that can reintegrate the skills and patterns associated with each developmental stage. Studies and case vignettes have illustrated the use of KMP rhythms to help children experience boundaries, embody strength, increase emotional flexibility, exhibit control and mastery over their bodies, and develop healthy emotional bonds with their parents (Loman, 1998).

The concept of being seen serves as a pivotal component of DMT that makes it effective when working with children. Children need to be seen and understood, and the DMT processes of attunement and mirroring between dyads give children nonverbal information about their being seen and understood. The acknowledgement that our bodies are vehicles for early life experiences, and that children depend on the use of their body for communication and expressivity makes DMT a potential tool for intervening in issues related to adoption, trauma, and attachment. The value of DMT in parent/child dyads is rooted in its potential for supporting interpersonal connections, regulation, and development (Tortora, 2006).

DMT has also been evaluated as a treatment that fulfills the needs of adoptive parents through focusing on parent-child connection, exploring individual identities, promoting regulation skills, fostering self-awareness, and increasing familial bonds. The body's holding of trauma makes DMT an optimal intervention for children with involvement in foster care, because of its power to help heal their ability to form healthy caregiver relationships in the wake of a history of relationships that are disrupted (Glaser, 2014). Through a combination of DMT and art

therapy, children in foster care can access their experiences through creativity. Themes relevant to these children including deprivation of needs, shame, and control, which can be healthily expressed through these mediums (Gonick and Gold, 1992).

### **Dance/Movement Therapy and Trauma**

Movement and the body hold significant weight in one's relationship to traumatic experiences. When typical development is interrupted by trauma, these body level reactions are reflected and expressed through movement (Kestenber, 1999). Loss of a parent or other relational trauma damages the parent/child relationship and these memories are stored implicitly through kinesthetic, auditory, tactile, olfactory, visual and affective experiences (Malchiodi and Crenshaw, 2014). Early developmental trauma is deeply ingrained in the brain in primitive functions, and cannot reach resolve through verbal means (Perry, 2005).

Since trauma is stored as sensory memories on a body level (Hurwitz 2003; Klorer 2017), children must be approached therapeutically on the same body level through nonverbal access (Klorer, 2017). Approaching trauma survivors through the body allows clinicians to access the neurological impact of trauma and provide tools for the physiological regulation and transformation that translates into emotional regulation and transformation (Gray, 2017). Unlike other interventions, DMT highlights the value of the body and directly engages it within therapeutic experiences (Cristobal, 2018). DMT offers benefits both psychologically and physiologically to trauma survivors (Martinec, 2018). It goes hand in hand with trauma-informed care due to its reliance on movement to communicate, expressive foundations, and the integration of somatic, kinesthetic, and sensory experiences (Gray, 2015). Using the body in therapy can be invaluable in cases of body-oriented traumatic events such as physical abuse or injury, where the body is a source of fear (Martinec, 2018). Survivors of abuse, in particular,

experience the body as a source of pain, and dance/movement therapists are uniquely qualified to create therapeutic experiences that intentionally address the body in order to heal the psychological and emotional pain held within it (Ho, 2015). Since abuse and neglect are bodily experiences DMT uniquely addresses the need to heal them through the body (Goodill, 1987).

By re-choreographing patterns of engagement and response that are ingrained in the body, healing work can be practiced and actively reparative on a body level (Devereaux, 2014). With movement and touch, survivors can change their relationships to their bodies and reclaim their sense of their body and sense of self (Cristobal, 2018). Working with the body physically engages regulation tools, which are hindered following traumatic experiences (Devereaux, 2008). It allows clients to move, mobilize, and play without operating from a state of fear. As the expectation of instability and danger diminishes, the client will be better equipped to engage with others and develop interpersonal relationships (Devereaux, 2017). DMT can be particularly useful when working with children who experience trauma before acquiring verbal language. It is almost impossible for these events to be processed verbally in these cases, and DMT addresses these issues by not relying on verbal skills (Goodill, 1987). DMT can help trauma survivors experience strength, power, and control, developing safety through movements with these qualities. When combating the shame often associated with trauma, DMT helps to rebuild a positive body-image and increase self-esteem by incorporating movement tasks that fulfill a sense of mastery and pride over one's body and abilities (Kaban, 2003).

An empirically supported model suggests that DMT techniques can support trauma survivors in achieving safety, regulating hyperarousal, and activating interoception (Dieterich-Hartwell, 2017). In the development of a program for childhood sexual abuse survivors, DMT is presented as a modality that can increase personal insights and self-esteem in order to reduce

distress and inspire personal growth. Through qualitative feedback, it was concluded that DMT helps clients develop their personal concepts of boundaries and self, and provides feelings of control and safety. Connecting to the floor through grounding was a specific intervention used to create security that supports freedom. DMT fostered awareness of self, body, others, boundaries, and emotions, and increased awareness helps survivors better understand their experiences and the impact they have on their present life (Ho, 2015).

While conducting DMT sessions with childhood sexual abuse survivors, key themes of reconnection to the body, permission to play, spontaneity, struggle, intimate connection, and freedom were identified. Participants reported feeling increased body connection, acceptance, security, and understanding of their emotional selves after participating in DMT. They reunited their mind and bodies, and, through the playfulness of DMT, they were able to balance the more taxing moments of the therapy and experience relief from emotional stress and struggle. DMT also supported a sense of personal freedom, by putting participants' control over their bodies at the forefront, and reclaiming the self through the body (Cristobal, 2018). A case studying the use of DMT with a family exposed to domestic violence emphasized its ability to re-choreograph family relational patterns and dynamics, and support self-regulation. The results for this family included increased empathic communication skills, self and body awareness, and capacity for self-regulation (Devereaux, 2008).

A proposed model of DMT for trauma treatment utilizes movement techniques to achieve safety, stability, integration of traumatic memories, and development of the relational self. Interventions proposed in the model include attunement, mirroring, grounding, sensory stimulation, 5-sense perceptions, breathing exercises, interactional movement, symbolism, creative expression, and group movement. This model emphasized how bodily involvement

supports right brain integration, which is impaired during developmental trauma. DMT was suggested as an approach in developmental trauma treatment, specifically with dissociative symptoms, and that it can support positive results in regulation, expression, and self-awareness that can contribute to relief from trauma symptoms (Pierce, 2014). Through the development of a DMT model for children in foster care, specific DMT characteristics, frameworks, and interventions were found to adequately address the issues of trauma and separation children in foster care face. This model created an organized structure for dance/movement therapists to utilize in developing trust, healthy attachments, expression of inner states, and the identification and treatment of maladaptive behaviors (Kaban, 2003).

In a short-term DMT program with children enduring post-earthquake trauma in Taiwan, dance/movement therapists noticed that with therapeutic holding on behalf of the therapist, children were able to liberate their bodies, thus making space for them to express themselves creatively. DMT allowed participants to express themselves and develop a positive view of and relationship with their bodies (Lee et. al, 2015). In its use with an adult survivor of torture, DMT helped the client to restructure her sense of self, and improved her ability to interact with others and build relationships (Gray, 2001). DMT has been suggested as an effective modality for individuals with PTSD, due to its integration of body, mind, and brain, and the ways traumatic events influence those entities (Levine & Land, 2015).

In case examples from work with abused children in a residential setting, dance/movement helped clients develop strength, obtain a positive body image, facilitate trust, build self-awareness, experience change, and support their interpersonal interactions and self-expression. DMT uncovered repressed and hidden feelings in these children by using symbolism,

dramatic play, and movement to create a non-threatening environment for those not ready or able to express themselves verbally (Goodill, 1987).

### **Dance/Movement Therapy, Attachment and Building Relationships**

DMT addresses neurobiological and physiological processes that other therapies ignore, and by being inclusive of both mind and body, it is a modality suited for fostering interpersonal connections (Tortora, 2006). DMT supports the growth of healthy attachment relationships because of how it can facilitate the nonverbal connections and presence that naturally build attachment between infants and mothers (Purvis, et al., 2007). The nonverbal component of attachment means that the body-based DMT approach lends itself greatly to the rebuilding of these relationships (Tortora, 2006). Through physically re-choreographing experiences, struggles, and patterns, the attachment relationship can be healed. DMT also helps to integrate functioning and expand movement vocabulary, which supports communication abilities that may be underdeveloped for children who lack healthy attachment experiences (Devereaux, 2014).

DMT has been studied in reference to the shared components of mirroring, the DMT intervention, and mirroring as conceptualized by neuroscientists observing attachment relationships (Berroll, 2006). The empathic internalization of shared affective experiences that occur between parent and child when they achieve attunement, and the similar DMT experience of empathic connection through shared nonverbal experiences were discussed. Literature on both understandings of mirroring illustrated the natural human capacity for knowing, relating to, and understanding one another, and provides evidence on how DMT harnesses this ability to develop connections in therapeutic environments (Berroll, 2006). In a study reflecting on the experience of providing DMT to a child with Reactive Attachment Disorder, use of bodily attunement and

reliance on nonverbal communication proved to be reparative for damaged attachment experiences (Young, 2010).

A body level connection between caregivers and children is necessary in combating attachment difficulties, to demonstrate availability and combat the internalized, isolating message many children hold that they are alone against the world (Purvis, et al., 2007). DMT physically supports these connections through sensory touch, visual proximity, eye contact, and shared activities that require active social responsiveness.

Shared positive experiences are necessary for resolving disorganized attachments, and DMT provides these opportunities. (Levy, 1995). Through shared movement activities, children can feel seen and joined with, which significantly supports the rebuilding of a secure attachment (Devereaux, 2014). By deepening playful engagement between children and caregivers, more positive interactions can occur, strengthening the relationship (Glaser, 2014).

DMT can also foster environments of consistency, trust, and empathy, supporting therapeutic relationship development for parent/child dyads (Devereaux, 2014). Relationships require trust, and trust develops through feelings of safety, which begin in the body (Gray, 2017). By nonverbally recognizing and responding to one another, trust is established (Devereaux, 2014). Through activities that highlight contingent parental responses, a child's developing sense of expectancy contributes to healing the attachment relationship (Tortora, 2010). Intentionally identifying a child's nonverbal style and matching it sends an unspoken message that they are seen, valued, and being responded to through this connection. DMT can address temperamental mismatches, and help a parent utilize their strengths to connect to their child in situations where they may feel insecure about their abilities (Levy, 1995). When a family is experiencing challenges in their relational dynamics, such as with adoptive families, DMT can help members

re-choreograph their patterns in order to foster healthy attachment relationships they may have been missed, lost, or broken (Devereaux, 2008).

In parent/child dyads, DMT promotes awareness in the caregiver of the child's cues, and fosters a nonverbal dialogue that reveals both the strengths and pathology within the dyad's relationship. Parents can expand their movement repertoire after gaining a better understanding of both their own and their child's movement preferences, which can empower them to better attune, respond, and connect to their child (Glaser, 2014).

### **The Dance/Movement Therapist**

Dance/movement therapists are trained to use movement observation skills in treatment and, by studying movement, they receive information on early-life developmental experiences, coping strategies, and characteristics of one's personality and behavioral patterns (Kestenberg, 1999). The therapist can observe interactional patterns and regulation cues within the relationship. Through these nonverbal dialogues and movement actions, relational styles, expressive mechanisms, responses to arousal and engagement levels can be assessed. Often, nonverbal expressions occur outside of conscious awareness, and DMT can help clients identify and explore their expressions (Tortora, 2013). The dance/movement therapist develops their therapeutic relationships through movement, which enhances their understanding and ability to develop connections, tension relief, and nonverbal dialogues among dyads (Devereaux, 2008). A dance/movement therapist's training equips them with movement tools that can be used to help caregivers and children better diversify, understand, and intentionally utilize their movements. For example, when tending to regulation issues, a dance/movement therapist might introduce widening and narrowing movements, which help physicalize the concepts of balance and

stability (Betty, 2013). The ability to describe, and reflect movement gives dance/movement therapist's opportunities to access the unconscious through the body (Pierce, 2014).

Nonverbal interactions can reveal how parents and children see each other, and how each individual is motivated and understands themselves and others (Tortora, 2010). When working in dyads, a dance/movement therapist is equipped to observe matching and clashing patterns, drives, and defenses (Kestenberg, 1999). DMT can motivate and provide access to change mechanisms to alter maladaptive or unsuccessful interaction patterns. When working with families, dance therapists can support parents by identifying and reflecting the nonverbal cues at play in their relationships, which helps facilitate meaningful parent/child dialogues (Levy, 1995).

Dance/movement therapists can achieve maximal understanding of clients through embodied attunement and, from this inner sensing of their clients, they can experience individual dynamics of holding and movement. Dance/movement therapists meet clients where they are, and nonverbally attune and kinesthetically empathize with children and caregivers, which aids in a uniquely deep understanding of the dynamics between the parent and child. Dance/movement therapists can develop multisensory attunement skills in clients to improve their engagement with one another (Tortora, 2010). Dance/movement therapists are trained to be aware and intentional regarding their own internal and external states, which enables them to regulate themselves and be a partner in co-regulation with clients. Through holding intense emotional states, and a calm, attuned presence, the dance/movement therapist creates a safe emotional environment that gives access to interpersonal functioning (Devereaux, 2017). As the dance/movement therapist helps parents develop increased self and body awareness, they are more equipped to regulate themselves, and participate in responsive caregiving that allows for mutual regulation and healthy attachment building to occur (Tortora, 2006).

### **Dance/Movement Therapy Interventions with Parents and Their Adopted Children**

In DMT, attunement is considered the process of responsively duplicating muscle tension fluctuations, which fosters mutual empathy through physically representing responding to needs and feelings. Relational understanding, like in the parent/child dyad, can be achieved through visual, tactile, and auditory attunement (Kestenberg, 1999). Exchanges that are kinesthetically attuned help secure attachment relationships, provide comfort, promote feelings of safety, facilitate understanding, and increase emotional regulation skills (Devereaux, 2014).

Mirroring movement is a technique that increases connection and understanding. It is a communication tool that is used intentionally in DMT but exists naturally in attachment relationships through facial expression, gesture, and postural choices (Malchiodi and Crenshaw, 2014). Matching a child's behavior increases intimacy and attachment. Synchrony, mirrored actions, mutual sounds, eye contact, and matching in phrasing, speed, and vocal inflections offer companionship, and shared experiences (Purvis, et al., 2007). Mirroring builds capacity for empathic relationships by creating embodied senses of validation, acknowledgement, and understanding (Devereaux, 2008). Mirroring helps clients learn about themselves through others, similar to an infants' developing of self-concept through their conceptualization of others.

Both mirroring and attunement are valuable in addressing issues of attachment since they are reflective tools in which nonverbal responsiveness to cues signals understanding of emotional states and needs, which are often lost experiences for those with unresponsive, absent, or misattuned caregivers (Pierce, 2014). Connecting on a physical level through mirroring and attuning can help children experience matching and understanding of their needs, when they may have a history of clashing and being misunderstood by caregivers. This felt sense of being understood can generate trust between children and caregivers (Kaban, 2003).

Grounding exercises can be utilized to fully experience, understand, and connect to one's body and reality. It can be particularly helpful when treating clients with traumatic histories who experience dissociative symptoms, because of its ability to re-acclimate them to their present state. Grounding interventions provide feelings of stability and connection on physical, environmental, relational, emotional, and sensory levels (De Tord and Bräuninger, 2015). A secure and steady awareness of the body, self, and current states can support both caregivers and children in making connections in the present moment, and overcome challenging circumstances from their past relationships. Solid connection to the ground can provide security that enables people to feel safe when freely moving and exploring (Ho, 2015). Self-referential movements, through self-touch or feeling the feet or body on the floor bring awareness to the present self through the body, and can help address depersonalization symptoms (Pierce, 2014).

DMT invites experimentation with spatial dynamics, which is reflective of early life proximity patterning within the attachment relationship. Discovering awareness of desires for closeness or distance supports flexibility and understanding. Children can experience moving away from or towards their caregiver, and physically explore dynamics within a held space. Through these activities, dyads can redevelop the exploratory system that naturally occurs in secure attachments, where children feel safe to leave a reliable caregiver, knowing they will be there when they return (Devereaux, 2014). Exploring kinesphere, or the space around an individual that they move within, can be valuable for abused or neglected children because it offers control over personal boundaries and space (Goodill, 1987). As children explore personal kinesphere qualities and their preferences for designing and communicating the size and shape of their container, they explore their approaches to building relational bridges by releasing those boundaries (Devereaux, 2014).

Props can support spatial play as well as connective interventions that foster attunement, awareness, and communication within the self/other relationship. Stretch fabrics, balls, and scarves create a physical barrier between direct interaction, providing opportunities for connections that are less threatening. By using props interactively between parents and children, they can become a visual representation for the connection and attachment relationship between them (Devereaux, 2014). Props can also act as concrete representations and structures surrounding the more abstract, mature idea of attachment for children (Kaban, 2003).

Music can be utilized in attachment focused DMT to use auditory stimuli as an external container within the environment that creates embodied connection through shared sensory information (Devereaux, 2014). Additionally, rhythm and rhythmic movement can be utilized to express experiences in an organized, contained way. Rhythm provides predictability, and safety in a contained and organized structure. Through this sense of security, clients can feel increased strength and comfortability in interacting with others (Levy, 1988).

Sensory activities enhance processing and relational abilities that were limited or impaired early on in life (Purvis, et al., 2007). Simple sense perceptions, such as feeling one's hands on the wall, or seeing a colored carpet, aid in regulation through supporting awareness of the present moment and the safety of it (Pierce, 2014). Improvisational activities encourage flexible responsiveness for both parents and children, deepening interactional skills (Tortora, 2010). They are also valuable in accessing the unconscious (Pierce, 2014).

### **Discussion**

While extensive literature exists on therapeutic methods for treating attachment problems, trauma, and children both in and adopted out of foster care, studies on DMT with this population are limited. Literature demonstrates DMT's significant results in developing

nonverbal bonds and promoting resolution of trauma. The principles of DMT rely on the importance of the body in our functioning, awareness, relationships, and understanding of self. Like DMT, trauma and attachment literature and theories acknowledge and depend on principles of the mind-body connection to highlight the importance of nonverbal experiences. The essence of DMT is to look to the body as a resource and tool in resolving problems, and it is widely accepted and proven to be a resource and tool in treating issues related to trauma, children, and attachment. This mutual focus on movement and the body across these domains of research contributes to the argument for DMT as a chosen course of treatment for children adopted from foster care.

As established through trauma, attachment, and DMT literature, DMT presents as an effective modality for resolving attachment issues in traumatized children. Children who are adopted through foster care can benefit from dyad DMT with their caregiver, and through this modality they can strengthen their bond, work through relational obstacles, and mutually recognize and express their experiences. Four main factors contribute to the potent potential of DMT with this population: the necessity for nonverbal approaches when treating children, the role of movement and nonverbal interactions in attachment building, the bodily impact of physical and emotional trauma, and DMT's ability to address the primary goals of attachment based work. DMT fulfills this population's need for nonverbal, body-based interventions and should be prioritized as a method of treatment with this population.

### **Dance/Movement Therapy and Children**

Verbal methods of treatment fail to support in children reaching their full expressive and explorative potential. Limited language abilities, self-awareness, and cognitive processing skills

act as barriers for children placed in verbal therapy programs. Active, physicalized modalities serve children more fully by providing opportunities for embodiment, full range of expression, and active participation. They are the most efficient way to treat all children, and children seeking resolution in attachment issues have significantly more complex needs that must be considered when choosing a treatment. DMT is an active modality, that serves the mind through the body. By using the common, intuitive language of movement as an entry-point into children's inner experiences, dance/movement therapists support them in understanding, conceptualizing, and externally expressing those experiences. DMT supports healthy attachments by developing awareness, empathy, trust, and bonds in a universally understood way that verbal therapy cannot.

### **Dance/Movement Therapy and Attachment**

Attachment theorists agree that attachment is built, maintained, and broken through nonverbal communication. Early-life movement experiences with caregivers have a strong influence on our cognitive, social, and emotional development. These dances of interactions continue throughout our lives and into our relationships, profoundly impacting our perception of self, others, and relationships. If early-life nonverbal interactions do not produce a secure attachment, a child will behave, relate, and communicate in a way that reflects this deficit. Trust and responsiveness must develop on a body-level to build an attachment with a caregiver.

DMT directly addresses these nonverbal interactions and can support dyads in experiencing them. Through the use of attunement, mirroring, and spatial dynamics, dance/movement therapists can support the re-creation of early-life attachment behaviors. Dance/movement therapists can utilize movement analysis and embodiment practices to assess a

parent-child dyad's current nonverbal communications and relationship dynamics, to best progress with treatment in a way that fulfills their unique needs. No other therapeutic modality can process and evaluate nonverbal cues with the expertise of a dance/movement therapist, and they have the unique ability to create and employ movement interventions that actively address the nonverbal experiences of their clients. Secure attachment relationships develop on a body level, and by bringing treatment to a body level, these relationships can be built.

Attachment theories rely on the notion that physical, nonverbal experiences contribute greatly to the emotional development of an attachment. This perceived connection between external bodily experiences and internal cognitive and emotional experiences aligns directly with DMT's guiding principles. DMT is based on the mind/body connection and the relationship between internal and external experiences. This alignment in theoretical foundations makes DMT an exemplary modality to approach attachment issues with.

### **Dance/Movement Therapy and Trauma**

Like attachment, trauma is also ingrained in the body. When an individual experiences trauma, these memories are stored throughout the body. Children who have experienced abuse and neglect may have limited cognitive processing and recall abilities on a conscious level, but these instances are externally reflected in their styles of relating, cognitive functioning, emotional dynamics, and behavior. These body-based memories are best uncovered, processed, and healed through a body-based modality. DMT offers a unique perspective in trauma recovery, by directly addressing the body and using it as a tool to express and explore one's experiences. DMT is a body-based modality that respects, acknowledges, and utilizes the role of the body in traumatic experiences to maximize the healing experience. Children who have experienced

trauma can better understand, express, and move on from traumatic memories when addressing it through their bodies. Trauma literature references the relationship between the physical and internal components of trauma, and the role of the body in storing, remembering, and responding to trauma. The mind/body connection is highlighted in trauma studies, and when approaching trauma survivors therapeutically, a treatment that also emphasizes this connection is necessary. DMT utilizes the mind/body connection in the therapeutic process, serving as an ideal treatment of choice when a client is overcoming the impact of traumatic experiences.

### **Dance/Movement Therapy and Building Attachment Between Adoptive Parents and Their Children**

DMT can support caregivers in fostering safety and trust within their relationships. Through movement exercises and interventions regarding responsiveness, proximity, and attunement, parents can recreate missed experiences of reliability and availability within the parent/child dyad. DMT's creative and expressive nature can support dyads in engaging in playful interactions, deepening positive bonds and creating healthy bodily memories of joyful experiences together. It supports the need for unconditional love and acceptance by identifying and working through clashing or unsuccessful nonverbal interactions.

With their unique training in movement analysis and nonverbal communication, dance/movement therapists can address conflicts within relationships, and support empathic connections among dyads that make both individuals feel valued. Through the body, parents and children can better understand the connection between external and internal sensations, facilitating greater emotional awareness. Being in tune with one's emotional life equips participants to express and share those inner experiences. Additionally, by accessing emotional

experiences through the body, DMT can offer interventions and tools for emotional regulation. DMT's use of touch, movement, props, and music offers rich opportunities for the multisensory stimulation that helps children with poor attachment histories integrate disrupted development. The need to re-create missed experiences is powerfully fulfilled through DMT, which literally provides opportunities to re-choreograph these patterns through active, embodied means that engage the body, effectively engaging the mind. In DMT, children explore boundaries, reconnect to their bodies, and learn to manage their internalized concepts of self and other.

### **Next Steps**

Drawing on attachment, trauma, and DMT literature, we can conclude that DMT is a practical and powerful choice of treatment for children adopted from foster care. While little data exists observing DMT with this population, this assessment of needs, and collection of literature highly suggests its effectiveness. Future studies are necessary to develop further the rationale for DMT, and through actively investigating the use of DMT with these parent/child dyads, more empirical support can be generated. More in-depth research into the intermingling relationships among trauma, attachment, foster care, adoptive families, the body, and DMT could also provide complimentary data that would add to this literature review and provide further evidence that illustrates the efficacy of DMT with this population. Increased awareness of DMT among clinicians and social workers involved in the foster care and adoptive systems could begin the process of providing DMT to this population, and would also help facilitate an increase in studies that would test the proposed effectiveness.

### **Conclusion**

Whether it is the act of separating from a caregiver, or a history of abuse and neglect, children placed in foster care have experienced trauma and disrupted attachment. When they are adopted into forever families, their traumatic pasts present a barrier to forming healthy attachments with caregivers. Without a stable attachment relationship, these children will be at risk for detrimental social patterns, crime, addiction, mental health and behavioral problems, and damaging relationships for the rest of their lives. Adoptive families miss the chance to form these attachments during critical periods of many children's lives, but informed treatment can offer opportunities to develop them. DMT is a therapeutic modality that directly addresses the body, the primary vehicle for attachment building and the holding of traumatic experiences. Parents, clinicians and community workers who play roles in the lives of children adopted through foster care should advocate for DMT as the treatment of choice when seeking resources to promote healthy attachment relationships in the wake of trauma. With effective treatment, such as DMT, children adopted from foster care can build healthy attachments, resolve traumatic experiences, and live full, empowered lives despite the difficulties they faced early on in life. DMT addresses the attachment and trauma-oriented issues children adopted from foster care face, and by doing so, it offers the opportunity to positively and permanently change the course of their lives and the lives of their forever families.

## References

- Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In B. Cardwell & H. Ricciuti (Eds.), *Review of child development research* (Vol. 3, pp. 1-94) Chicago: University of Chicago Press.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development*, 41, 49-67.
- Bennett, S., & Blome, W.W., (2013). Attachment-based clinical work with children and adolescents. In *Implementing attachment theory in the child welfare system: Clinical implications and organizational considerations* (pp. 259-283). New York, NY: Springer  
New York: Springer. doi:10.1007/978-1-4614-4848-8\_12
- Berrol, C. (2006). Neuroscience meets dance/movement therapy: Mirror neurons, the therapeutic process and empathy. *The Arts in Psychotherapy*, 33(4), 302-315.  
doi:10.1016/j.aip.2006.04.001
- Bettmann, J., & Friedman, D. (Eds.). (2013). *Attachment-based clinical work with children and Adolescents* (Essential clinical social work series). New York: Springer.
- Betts, D. (2003). *Creative arts therapies approaches in adoption and foster care: Contemporary strategies for working with individuals and families*. Springfield, Ill., U.S.A.: Charles C Thomas.
- Betty, A. (2013). Taming tidal waves: A dance/movement therapy approach to supporting emotion regulation in maltreated children. *American Journal of Dance Therapy*, 35(1), 39-59.

- Birn, R., Roeber, B., & Pollak, S. (2017). Early childhood stress exposure, reward pathways, and adult decision making. *Proceedings of the National Academy of Sciences, 114*(51), 13549-13554. doi:10.1073/pnas.1708791114
- Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis, 39*, 350-371.
- Bowlby, J. (1969). *Attachment. Attachment and loss: Vol. 1. Loss*. New York: Basic Books.
- Bowlby, J. (1973a). *Attachment and loss (vol. 2), Separation: Anxiety and anger*. New York: Basic Books. Penguin Books, 1975.
- Bowlby, J. (1980). *Attachment and Loss (vol. 3), Loss: Sadness and Depression*. New York: Basic Books. Penguin Books, 1981.
- Bowlby, J. (1988a). *A Secure Base: Clinical Applications of Attachment Theory*. London: Routledge.
- Child Welfare Information Gateway. U.S. Department of Health and Human Services (2018). *Introduction to Adoption*.
- Cristobal, K. (2018). Power of touch: Working with survivors of sexual abuse within dance/movement therapy. *American Journal of Dance Therapy : Publication of the American Dance Therapy Association, 40*(1), 68-86. doi:10.1007/s10465-018-9275-7
- De Tord, P., MA (Dance Movement Therapy), BA (Communication Science), & Bräuninger, I., PhD, MA, BTM, ADMTE. (2015). Grounding: Theoretical application and practice in dance movement therapy. *The Arts in Psychotherapy, 43*, 16-22.  
doi:10.1016/j.aip.2015.02.001
- Devereaux, C. (2008). Untying the knots: Dance/movement therapy with a family exposed to domestic violence. *American Journal of Dance Therapy, 30*(2), 58-70.

- Devereaux, Christina. (2014). *Moving the Space Between Us The Dance of Attachment Security. Creative arts and play therapy for attachment problems* (Creative arts and play therapy). New York: Guilford Press.
- Devereaux, C. (2017). Neuroception and attunement in dance/movement therapy with autism. *American Journal of Dance Therapy*, 39(1), 36-38.
- Dieterich-Hartwell, R. (2017). Dance/movement therapy in the treatment of post traumatic stress: A reference model. *The Arts in Psychotherapy*, 54, 38-46. doi:10.1016/j.aip.2017.02.010
- Forbes, H., & Post, B. (2006). *Beyond consequences, logic, and control: A love-based approach to helping attachment-challenged children with severe behaviors* (1st ed.). Orlando, FL: Beyond Consequences Institute. (Fried & Leventhal, 1995)
- Levy, F. (1995). *Dance and other expressive art therapies: When words are not enough*. New York, NY: Routledge, Taylor & Francis Group.
- Glaser, E., & Columbia College (Chicago, Ill.). Creative Arts Therapies Department. (2014). *Creating family: A phenomenological needs-assessment of adoptive parents for implications in dance/movement therapy* (Unpublished doctoral dissertation). Columbia College Chicago.
- Gonick, R. & Gold, M. (1992). Fragile attachments: Expressive arts therapy with children in foster care. *The Arts in Psychotherapy*, 18, 433-440.
- Goodill, Sharon. (1987). Dance/movement therapy with abused children. *The Arts in Psychotherapy*, 14, 59-68.
- Gray, A. (2001). The body remembers: Dance/movement therapy with an adult survivor of torture. *American Journal of Dance Therapy*, 23(1), 29-43.  
doi:10.1023/A:1010780306585

- Gray, A. (2015). Dance/movement therapy with refugee and survivor children: A healing pathway is a Creative Process In. Perry, B.D. and Malchiodi C. (Ed.), *Creative interventions with traumatized children* (pp 3-23). New York, NY: Guilford Press.
- Gray, A. (2017). Polyvagal-informed dance/movement therapy for trauma: A global perspective. *American Journal of Dance Therapy : Publication of the American Dance Therapy Association*,39(1), 43-46. doi:10.1007/s10465-017-9254-4
- Harvey, S. (2003). Dynamic Play with an Adoptive Family Struggling With Issues of Grief, Loss, and Adjustment. In *Action therapy with families and groups : Using creative arts improvisation in clinical practice*(1st ed.). Washington, D.C.: American Psychological Association.
- Harvey, S. (2003a). Dynamic Play Therapy with Adoptive Families. In *Creative arts therapies approaches in adoption and foster care : Contemporary strategies for working with individuals and families*. Springfield, Ill., U.S.A.: Charles C Thomas.
- Herrenkohl, T., Jung, H., Lee, J., & Kim, M., (2017). *Effects of Child Maltreatment, Cumulative Victimization Experiences, and Proximal Life Stress on Adult Crime and Antisocial Behavior*. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/250506.pdf>
- Hinz, L. (2003). Art Therapy Approaches with Unbonded Children and Adolescents. In *Creative arts therapies approaches in adoption and foster care: Contemporary strategies for working with individuals and families*. Springfield, Ill., U.S.A.: Charles C Thomas.
- Ho, R. (2015). A place and space to survive: A dance/movement therapy program for childhood sexual abuse survivors. *The Arts in Psychotherapy*, 46, 9-16.  
doi:10.1016/j.aip.2015.09.004
- Hoeve, M., Dubas, J., Eichelsheim, V., Laan, V., Smeenk, W., & Gerris, J. (2009). The

- relationship between parenting and delinquency: A meta-analysis. *Journal of Abnormal Child Psychology*, 37(6), 749-775.
- Hoeve, M., Stams, G. J., van der Put, C. E., Dubas, J. S., van der Laan, P. H., & Gerris, J. R. (2012). A meta-analysis of attachment to parents and delinquency. *Journal of Abnormal Child Psychology*, 40(5), 771-85.
- Hughes, D. (2006). *Building the bonds of attachment: Awakening love in deeply troubled children* (2nd ed.). Lanham, Md.: Jason Aronson.
- Hughes, D. (n.d.). Dyadic Developmental Psychotherapy: Toward a Comprehensive, Trauma Informed Treatment for Developmental Trauma Disorder. Retrieved from <https://ddpnetwork.org/backend/wp-content/uploads/2014/03/DDP-Toward-a-Comprehensive-Treatment-Dan-Hughes.pdf>
- Hurwitz, Allison (2003). The Use of Art Therapy with Children in Foster Care. In D.J. Betts (Ed.) *Creative arts therapies approaches in adoption and foster care: Contemporary strategies for working with individuals and families* (pp. 168-189). Springfield, Il.: Charles C. Thomas.
- Hussey, D. and Layman, D. (2003). Music Therapy Issues and Strategies for Working with Adopted and Foster Care Children. In *Creative arts therapies approaches in adoption and foster care: Contemporary strategies for working with individuals and families*. Springfield, Ill., U.S.A.: Charles C Thomas.
- Johnson, D. and Lubin, H. (2003). Use of Ceremony in Multiple Family Therapy for Psychological Trauma. In *Action therapy with families and groups: Using creative arts improvisation in clinical practice* (1st ed.). Washington, D.C.: American Psychological Association.

- Kaban, M.J. (2003). *A dance/movement therapy treatment model for foster children* (Master's Thesis). Retrieved from <https://idea.library.drexel.edu/islandora/object/idea%3A2651>
- Kaiser, D. (2003). Alien, Joker, Animal, Human: The Story of an Adoptee's Quest in Simultaneous Treatment Using Art Therapy. In *Creative arts therapies approaches in adoption and foster care: Contemporary strategies for working with individuals and families*. Springfield, Ill., U.S.A.: Charles C Thomas.
- Klorer, P. (2017). *Expressive therapy with traumatized children* (Second ed.). Lanham: Rowman & Littlefield.
- Kestenberg Amighi, J. (1999). *The meaning of movement : Developmental and clinical perspectives of the Kestenberg movement profile*. Amsterdam, Netherlands: Gordon and Breach.
- Lee, T., Lin, Y., Chiang, C., & Wu, M., Graduate Institute of Multicultural Education, National Dong Hwa University, Taiwan. (2013). Dance/movement therapy for children suffering from earthquake trauma in taiwan: A preliminary exploration. *The Arts in Psychotherapy*, 40(1), 151-157. doi:10.1016/j.aip.2012.12.002
- Levine B, Land HM (2015) A Meta-Synthesis of Qualitative Findings About Dance/Movement Therapy for Individuals With Trauma. *Qual Health Res* 26: 330-344.
- Levy, F. (1988). *Dance/Movement Therapy: A Healing Art*. Reston, VA: American Alliance for Health, Physical Education, Recreation and Dance.
- Lewis, Penny. (1999). Healing Early Child Abuse: The Application of the Kestenberg Movement Profile and Its Concepts. *The meaning of movement : Developmental and clinical perspectives of the kestenberg movement profile*. Amsterdam, Netherlands: Gordon and Breach.

- Loman, S. (1998). Employing a developmental model of movement patterns in dance/movement therapy with young children and their families. *American Journal of Dance Therapy*, 20(2), 101-115. doi:10.1023/A:1022100511657
- Loman, S. (2016). Judith s. Kestenberg's Dance/Movement Therapy Legacy: Approaches with pregnancy, young children, and caregivers. *American Journal of Dance Therapy*, 38(2), 225-244.
- Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95-124). Westport, CT, US: Ablex Publishing.
- Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M.T. Greenberg, D. Cicchetti & E.M. Cummings (Eds.), *Attachment in the Preschool Years* (pp. 121–160). Chicago, University of Chicago Press.
- Malchiodi, C. (2015). Neurobiology creative interventions, and childhood trauma In. Perry, B.D. and Malchiodi C. (Ed.), *Creative interventions with traumatized children* (pp 3-23). New York, NY: Guilford Press.
- Malchiodi, C., & Crenshaw, D. (2014). *Creative arts and play therapy for attachment problems* (Creative arts and play therapy). New York: Guilford Press.
- Martinec, R. (2018). Dance Movement Therapy in the Wider Concept of Trauma Rehabilitation. *Journal of Trauma and Rehabilitation* 1(1), 1-5. Retrieved from [https://www.scitechnol.com/peer-review/dance-movement-therapy-in-the-wider-concept-of-trauma-rehabilitation-gmCh.php?article\\_id=7765](https://www.scitechnol.com/peer-review/dance-movement-therapy-in-the-wider-concept-of-trauma-rehabilitation-gmCh.php?article_id=7765)
- Perry, B.D. (2005). Applying principles of neurodevelopment to clinical work with maltreated

- and traumatized children: The neurosequential model of therapeutics N. Boyd-Weber (Ed.), *Working with Traumatized Youth in Child Welfare* (pp. 27-52). New York, NY: Guilford Press.
- Perry, B. D. (2013). Bonding and Attachment in Maltreated Children: Consequences of Emotional Neglect in Childhood. Retrieved from [https://childtrauma.org/wp-content/uploads/2013/11/Bonding\\_13.pdf](https://childtrauma.org/wp-content/uploads/2013/11/Bonding_13.pdf)
- Pierce, L. (2014). The integrative power of dance/movement therapy: Implications for the treatment of dissociation and developmental trauma. *Arts in Psychotherapy, 41*(1), 7-15. doi:10.1016/j.aip.2013.10.002
- Purvis, K.B., Cross, D.R., & Sunshine, W.L. (2007). *The connected child: Bring hope and healing to your adoptive family*. New York: McGraw-Hill.
- Renschler, T., Lieberman, A., Hernandez Dimmler, M., & Burke Harris, N. (2013). Attachment based clinical work with children and adolescents. In *Trauma-focused child-parent psychotherapy in a community pediatric clinic: A cross-disciplinary collaboration* (pp. 115-139). New York, NY: Springer New York: Springer. doi:10.1007/978-1-4614-4848-8\_6
- Schofield, G., Beek, M., & British Association for Adoption & Fostering. (2014). *The secure base model: Promoting attachment and resilience in foster care and adoption*. London: British Association for Adoption and Fostering (BAAF).
- Spatz Widom, C., Ph.D., & Hiller-Sturmhofel, S., Ph.D. (2001). Alcohol abuse as a risk factor for and consequence of child abuse. *Alcohol Research & Health, 25*(1), 52-57.
- Stepakoff, S. (2003). Searching for a Story That Makes Sense: Bibliotherapy with a 6-year old Boy in Transition from Long-Term Foster Care to Adoption. In *Creative arts therapies*

*approaches in adoption and foster care: Contemporary strategies for working with individuals and families.* Springfield, Ill., U.S.A.: Charles C Thomas.

Tortora, S. (2006). *The dancing dialogue: Using the communicative power of movement with young children.* Baltimore, MD: Paul H. Brookes.

Tortora, S. (2010). Ways of seeing: An early childhood integrated therapeutic approach for parents and babies. *Clinical Social Work Journal*, 38, 37-50. doi: 10.1007/s10615-009-0254-9

Tortora, S. (2013). Attachment-based clinical work with children and adolescents. In *The essential role of the body in the parent-infant relationship: Nonverbal analysis of attachment* (pp. 141-164). New York, NY: Springer New York: Springer.  
doi:10.1007/978-1-4614-4848-8\_7

Trauma Among Youth in the Juvenile Justice System (2016). Retrieved from  
<https://www.ncmhjj.com/wp-content/uploads/2016/09/Trauma-Among-Youth-in-the-Juvenile-Justice-System-for-WEBSITE.pdf>

U.S. Department of Health and Human Services. Administration for Children and Families, Children's Bureau. (2018). *The Adoption and Foster Care Analysis and Reporting System (AFCARS) Report.* Report No. 25.

Wiener, D., & Oxford, L. (2003). *Action therapy with families and groups: Using creative arts improvisation in clinical practice* (1st ed.). Washington, D.C.: American Psychological Association.

Young, K., & Columbia College (Chicago, Ill.). Dance/Movement Therapy & Counseling Department. (2010). *Emerging therapist, growing child : Developing a relationship with a child with a reactive attachment disorder*(Unpublished doctoral dissertation). Columbia

College Chicago.