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Breaking the Silence and Moving Voices: Dance/Movement Therapy in the Treatment of Male and Female Sexual Trauma Survivors

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BREAKING THE SILENCE AND MOVING VOICES:

DANCE/MOVEMENT THERAPY IN THE TREATMENT OF MALE AND FEMALE
SEXUAL TRAUMA SURVIVORS

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Abstract

The purpose of this research was to decipher the benefits and challenges of using a body-based therapy on male and female survivors of sexual trauma, to explore how dance/movement therapy is a therapeutic intervention that facilitates recovery within this population, and to illuminate whether gender socialization practices have an impact on how trauma is processed and emoted within the male and female bodies. The thesis provides information about common presenting problems, treatment models, and case studies for both sexes of this population. Using a loosely structured eleven count questionnaire, case studies, anecdotes, and movement observations employing Laban Movement Analysis terminology were gathered from six dance/movement therapists who worked with male and/or female survivors of sexual trauma. This data was analyzed, and emerging themes and observations were noted. To some extent, the analysis demonstrated the effectiveness of dance/movement therapy in the treatment of both sexes, the embodiment similarities between both sexes, and the continued challenges of addressing gender socialized misconceptions about sexual trauma. Future research questions and recommendations for continued research concerning this population using dance/movement therapy as a recovery method were noted.
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Introduction

On February 14th, 2013, women and men across the globe rose up and took to the streets to dance together and express their solidarity against violence on women and girls. The event, entitled One Billion Rising, a subset of the V-day organization, was created by Eve Ensler, author, performer, activist, and Tony award winning playwright. Ensler’s most infamous play, *The Vagina Monologues*, in which female monologists share the feminine experience, benefits the organization. Ensler declared on her website, www.vday.org,

More than 1 out of every 3 women on this planet will experience violence during her lifetime. With 7 billion people on the planet, that's one billion women. Stopping this violence is as crucial as addressing the issues of disease, hunger, and climate change. One Billion Rising is a global strike, a call to refuse to participate until rape and rape culture ends. It's a solidarity reach, a new refusal, and a new way of being. (VDay, 2013)

In Chicago, I danced in a flash mob for the event in Daley Center Plaza in the heart of the Chicago Loop. Joining me were at least one hundred people, women and men, dancing together to the One Billion Rising dance, choreographed by Emmy award winning actress and choreographer, Debbie Allen. The event itself was moving and uplifting. Local advocacies were handing out pamphlets and fliers as well as red scarves, the color representing the movement. What was noticeably absent was the media: there were no television news media present taping the event, and the few journalists walking around the plaza were from small, independent publications. It was disheartening to see that this moving and tremendous event was not broadcasted to a wider audience. Unfortunately, it also points to the level of indifference or apprehension discussing violence and sexual trauma.
According to the Rape, Abuse, and Incest National Network (or RAINN), 54% of all sexual assault is never reported to the police. Furthermore, every two minutes someone is sexually assaulted in America, and every year, there is an estimated 207,000 victims of sexual assault (RAINN, 2012). Within these statistics, one out of every six women has been a victim of attempted or completed rape in her lifetime, and one out of every 33 men has been the victim of attempted or completed rape (RAINN, 2012). The survivors are not the only silent party regarding the atrocities of sexual trauma. In social settings when asked about this thesis project, and the title was disclosed, the listening party became silent, mumbled a few words with raised eyebrows, and quickly changed the topic. I wondered, “Would society rather remain silent to the atrocity of sexual trauma?” In the book, *Trauma and Recovery: The aftermath of violence*, Dr. Judith Herman (1997), explains this phenomenon by stating:

To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events. When the events are natural disasters or “acts of God,” those who bear witness sympathize readily with the victim. But when the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator. (p.7)

Only when the case is of an “unusual” nature—such as men or boys being assaulted by prominent figures in society, religion, or media—does the incident and call to action get sounded by the media. These incidents of sexual abuse and assault mark the front pages of newspapers, magazines, and blogs, retelling the atrocity of the Penn State sexual abuse scandal, Catholic priests defaming their robes, and the increasing numbers of returning veterans not only with Post Traumatic Stress Disorder but Military Sexual Trauma (or MST). However, rape and sexual
trauma is ancient in history for females, and the “unusual” cases of male survivors are not so unusual. The phenomenon of sexual trauma is still something that needs to be recognized, discussed, and treated without common misconceptions.

Sexual violence is not only subjected upon women, or even young women for that matter. Sexual abuse and trauma does not discriminate in age, race, gender, culture, or socioeconomic status. According to Dr. Dee Spring, an art therapist, sexual trauma survivors are an “incident-specific population, bound together by a category of experience” (Spring, 2007, p. 17). She further stated that a dichotomy exists within this population of a need to deny and the will to proclaim. Response to the assault is shaped by the individual perception, ethno-cultural aspects, perspective, and beliefs, age, family history, coping ability, prior mental health before a traumatic incident, the type of incident experienced, and individual support systems (Peebles-Kleiger & Zerbe, 1998, as cited in Spring, 2007). However, regardless of the circumstances, anxiety, fear, guilt, and shame often mar the individual’s interpersonal and intrapersonal relationships, sometimes lasting over a lifetime. These emotions and psychobiologic responses often prevent the survivors voicing what happened to them to loved ones or the authorities (Spring, 2007). However, as more sexual assaults and survivors are becoming known in the media, understanding how to treat these individuals is becoming more of a necessity.

In my personal history, I have used dance as a cathartic tool towards recovery from traumatic and distressing life events. However, as a dancer and a female, I have my own biases and perspective towards utilizing my body to emote feelings and sensations. My biases of using dance to project my emotions and my comfort in utilizing my body became even more apparent compared to the clients I worked with as a dance/movement therapy (DMT) intern at the Jesse Brown VA Medical Center in the posttraumatic stress disorder (PTSD) unit. There, I also noticed
that men had a specific reaction to dance compared to women. I wondered whether societal interpretations of the body resulted in a difference between the male and female reactions to trauma and how that difference would manifest in dance and movement. In addition, this brought to mind the question on whether sexual trauma has a unique impact on the male and female psyche. Within this study, although I will not be focusing on veterans, I hope to expand the study of the effects of body-based therapy on trauma survivors with specific attention to those of a sexual nature. Furthermore, I will analyze if trauma is processed and expressed differently within the male and female body. In researching this topic, I was intrigued by the limited amount of empirical studies available for the study of DMT in the treatment of male sexual survivors; therefore, with this study, I hope to expand the amount of documentation available that DMT is a viable treatment for both male and female sexual trauma survivors.

**Research Questions or Hypotheses**

The main research questions that I hope to answer with this study are what are the challenges and benefits of using a body-based therapy on male and female survivors of sexual trauma, and how and if DMT is a therapeutic intervention that facilitates recovery. Furthermore, this study hopes to illuminate whether gender socialization practices have an impact on how trauma is processed and emoted within the male and female bodies.

**Definition of Key Terms**

The terms below appear throughout the thesis and for clarification purposes, the definitions appear below.
**Sexual Trauma** – Non-consensual forced physical sexual behavior of person(s) to another. Types include rape, incest, childhood molestation, date rape, war rape, or ritual abuse (Bernstein, 1995).

**Posttraumatic Stress Disorder** – A client who has experienced, or witnessed, or was confronted with an unusually traumatic event that has both of these elements: the event involved actual or threatened death or serious physical injury to the client or to others, and the client felt intense fear, horror, or helplessness. Furthermore, the client repeatedly relives the event in at least one of these ways:

- Intrusive, distressing recollections (thoughts, images).
- Repeated, distressing dreams.
- Flashbacks, hallucinations or illusions, feeling or acting as if the event were recurring (includes experiences that occur when intoxicated or awakening).
- Marked mental distress in reaction to internal or external cues that symbolize or resemble some part of the event.
- Physiological reactions (such as rapid heartbeat, elevated blood pressure) in response to these cues.

Symptoms are either acute (have lasted less than three months but no less than one month) or chronic (have lasted three months or longer) (Morrison, 2006, p. 269).

**Dance/movement Therapy** – “The psychotherapeutic use of movement as a process which furthers the emotional, cognitive, social and physical integration of the individual” (American Dance Therapy Association, 2009).
**Gender** – “A set of two or more grammatical categories into which the nouns of certain languages are divided, sometimes but not necessarily corresponding to the sex of the referent when animate, also the state of being male, female or neuter” (Collins, 2003).

**Body (LMA)** – The *how* of movement and the structural and physical characteristics of the human body while moving. This category was introduced by Laban, developed by Irmgard Bartenieff in her study of fundamental body patterns of connectivity or the specific organizations of the body, and defined by Hackney. It is responsible for describing which body parts are moving, which parts are connected, and which parts are influenced by others. It is believed that in order for harmony in movement to exist, there must be an integration of all six patterns of connectivity. Thus by integrating the body, the body can engage in stability to access mobility and mobility to access stability. The six patterns of connectivity are;

- **Breath** – “Includes cellular and lung respiration, key to fluidity of movement, internal shaping and the experience of inner space as three-dimensional…” (Hackney, 2002, p. 218).
- **Core-Distal** – Relationship of limbs to center of the body, or core. Also known psychologically as, the ability of the individual to extend out into space towards interpersonal relationships and come back to self.
- **Head-Tail** – Patterns the ability of the individual to have a flexible and supportive spine that allows them to move through the body’s internal vertical and establish a sense of self. This pattern is important for level changes in movement.
- **Upper-Lower** – This pattern emphasizes grounding, strength, and intention by the body’s ability to yield, push, reach, and pull through space. This pattern connects the
upper portion of the body with the lower portion of the body by connection and
activation from the core, or center.

- Cross-Lateral – This pattern emphasizes the multidimensional and diagonal
connections of the body that allows the ability to spiral with complex level changes
and locomotion.

(Hackney, 2002)

Effort (LMA) – The why of movement. It can be described as the connection between
the mover’s outer movements and inner attitude (Moore, 2012) or the “inner impulse—a
movement sensation, a thought, a feeling, or emotion—from which movement originates”
(Maletic, 2010, p. 9). The effort category comprises of four motion factors, Space, Weight, Time,
and Flow (Maletic, 2010). Each motion factor has two polarities, a fighting polarity (more
effortful) and an indulging polarity (less effortful). Motion factors’ definitions listed below can
be found in Moore’s (2012) Laban Movement Analysis and Harmonic Theory.

- Flow – the effort exerted to control movement. The Flow element consists of the
indulging attitude of freeing or the continuous going of movement that is difficult to
stop, and the fighting attitude of binding or controlled and restrained movement
(Moore, 2012, p. 73).

- Weight – the effort exerted to apply the right amount of pressure, which ranges from
fighting to indulging. The fighting attitude includes increasing pressure, or strong
weight, in which forcefulness and firmness are present; the indulging attitude includes
decreasing pressure or light weight, in which delicacy or lightness are present.
“Passive weight” refers to a heaviness of the body without forcefulness or use of weight (Moore, 2012).

- **Time** – the effort exerted to pace the movement. The indulging attitudes are sustained, or decelerating, and the fighting attitudes are sudden, quick, or accelerating (Moore, 2012).

- **Space** – the effort exerted to aim and orient movement. The indulging attitudes are indirecting, in which curvilinear plasticity and continuous changes in motion are made. The fighting attitudes are directing, in which linear aim with a singular focus is noted (Moore, 2012).

**Drives** – occur when three effort elements or motion factors are conducted simultaneously in a movement (Moore, 2012). Drive notated in the study:

- **Vision Drive** – Consists of Space, Flow and Time.

**States** – occur when two effort elements or motion factors are conducted simultaneous in a movement (Moore, 2012). States notated in the study:

- **Rhythm** – Weight and Time
- **Dream** – Weight and Flow
- **Remote** – Space and Flow
- **Mobile** – Flow and Time

**Space (LMA)** – The *where* of movement refers to motion in connection to the environment, spatial pathways, patterns, and tension (Moore, 2012).
**Kinesphere** – “the sphere of movement space immediately adjacent to the mover’s body, often defined as all the areas that can be reached without taking a step” (Moore, 2012, p.101). It consists of three spheres: near, middle, and far reach space.

**Near space** – area closest to the body within the kinesphere (Moore, 2012).

**Dimensions** – consist of the bi-polar directions in space. The three dimensions are the vertical dimension (up and down), the horizontal dimension (right to left), and the sagittal dimension (forward and backward) (Moore, 2012).

**Planes** – “are extensions of the linear dimensions creating flat two-dimensional surfaces” (Moore, 2012, p.106). The vertical plane has both height and width; the horizontal plane has both width and depth; and the sagittal plane has both depth and height.

**Shape (LMA)** – The *what* of movement, and the way the body moves through movement with regard to space and form.

**Shape forms** – Static shapes that the body makes. Some shape forms are Wall, which is flat and appears to extend more into the horizontal plane. Another is Screw, which is twisted or spiral and extending more into the vertical plane (Moore, 2012).

**Enclosing** – refers to Warren Lamb’s interpretation of Laban’s gathering shape quality. Gathering is one section of the gathering and scattering shape qualities, which describes how the body moves from “the periphery of the kinesphere towards the center of the body or outwards into the surrounding” (Moore, 2012, p.150). Enclosing occurs within shaping in the horizontal plane and is the opposite of spreading.
Retreating – Shape quality that occurs within shaping in the sagittal (forward and backward) plane; it is the opposite of advancing (Moore, 2012).
Literature Review

In researching this specific topic, several themes emerged and overlapped. To understand the complexities of this topic, this literature review is divided into three subsections. These sections are (a) Sexual Trauma and Gender Differences, which explores how the psyche is affected by sexual trauma and how men and women react to sexual trauma; (b) The Effects of Trauma on the Brain and Body, which examines the psychobiology of the brain and body in reaction to trauma; and lastly, (c) Dance/Movement Therapy in the Treatment of Sexual Trauma, which presents articles on how DMT is a viable method in treating sexual trauma wherein any instances of gender differences within DMT treatment will be noted.

Sexual Trauma and Gender Differences

In researching the topic of sexual trauma, there is a vast amount of literature and articles on the effects of sexual trauma on the female psyche. However, the amount of empirical research of sexual trauma on the male psyche and, more importantly, the treatment of male sexual trauma survivors, are limited. Furthermore, empirical research on the comparison of the male and female reaction to sexual trauma is rare. In an effort to organize this literature review, the articles pertaining to the female reaction to sexual trauma, which comprises most of the data, will be discussed first, followed by the articles pertaining to male sexual trauma survivors. Any articles that were found that compared each gender’s reaction to dance and movement will be presented last.

In Herman’s (1997) book, Trauma and Recovery, the history, effects, and treatment of sexual trauma was extensively documented. However, Herman’s book differentiated trauma experienced by men as combat-related and women as sexually related. Examples of the impact of
trauma were given throughout the book as statements only from male Vietnam veterans and female civilian rape survivors. Herman disregarded the possibility that males could also be victims of sexual assault and frequently used feminist rhetoric within the book to postulate that sexual assault is an act of men enacting power over women. For example, Herman cited feminist author, Susan Brownmiller with her quote,

Man’s discovery that his genitalia could serve as a weapon to generate fear must rank as one of the most important discoveries of prehistoric times… It is nothing more or less than a conscious process of intimidation by which all men keep all women in a state of fear. (p. 30)

This pinnacle of the feminist theory that a male dominated society has controlled the definitions of women, social structures, and institutions, including socialization patterns, ironically, has also hindered and harmed men (Brown, 1990). The harmful gender socialization practices and how they pertain to male survivors of sexual trauma will be discussed later in the men’s section of this literature review.

Although, Herman’s (1997) documentation was one-sided, the literature offered relevant research pertaining to the female experience. For example, one study detailed was that of Ann Burgess, a psychiatric nurse and Lynda Holmstrom, a sociologist who, in 1972, conducted a study on the psychological effects of rape. The study consisted of interviews over the duration of one year, from 92 women and 37 children, who had come into a Boston area emergency room after being sexually assaulted. From these interviews, Burgess and Holmstrom created a syndrome dubbed, “rape trauma syndrome” in which in the aftermath of rape, survivors complained of insomnia, nausea, startle response, and nightmares, as well as dissociative or numbing symptoms (Herman, 1997). As noted in the study, these symptoms coincide almost
identically the symptoms of combat veterans. Later, in 1980, these symptoms comprised a diagnosis of Posttraumatic Stress Disorder (Rothschild, 2000). In relation to the duration of the symptoms, the study appears to determine the diagnosis to be chronic. When Burgess and Holmstrom re-contacted the test subjects, four to six years after the initial interview, although three-fourths of the women felt that they had recovered, one in every four women (or 26 percent) felt that she had never fully recovered (Herman, 1997).

However, according to Dr. Dee Spring’s (2007) chapter entitled “Sexual Trauma: Conflict Resolution in The Use of Creative Therapies with Sexual Abuse Survivors,” not all survivors acquire PTSD. Spring offered an interesting theory into the long-term responses of the survivors. Spring wrote, after the trauma occurs, regardless of the circumstance or type of event, Acute Response immediately follows, which includes shock, stabilization, normalization, reorganization, acceptance, and resuming daily life. However, if the symptoms do not subside, a chronic condition (such as PTSD) can develop.

PTSD is not the only consequence of sexual trauma. In women, sexual trauma is known to lead to substance abuse and sexual risking taking behaviors (van der Kolk, 2002, Bailey, 2007); depression, eating disorders, and anxiety disorders (Rodriguez, Ryan, Vande Kemp, & Foy, 1997); and medical disorders (Kaltman et al. 2005). According to several studies, female child sexual abuse survivors are also more susceptible to re-victimization. A meta-analysis study conducted in 2001 estimated that 15 to 79% of female child sexual abuse survivors experienced adult rape (Roodman & Clum, 2001). Furthermore, female survivors of child sexual trauma also have significantly higher rates of intimate partner violence (Briere & Runtz, 1987). Another study reported by Ullman and Brecklin (2002) concluded that 73% of their sexual assault
respondents experienced a traumatic life event other than sexual trauma and thus, in turn, attributed to a greater risk of PTSD.

Taking the aforementioned into perspective, Kaltman, Krupnick, Stockton, Hooper and Green’s (2005) study, “Psychological Impact of Types of Sexual Trauma on College Women,” hypothesized that women who experienced more frequent and severe sexual trauma at an early age would encounter more severe outcomes than those survivors who had less frequent, less violent sexual trauma, or experienced the trauma at an older age. Their study consisted of 125 college sophomore women, predominately white (23%) who were interviewed and screened for specific trauma histories. Participants were then separated into five separate groups: no trauma, childhood sexual assault, adolescent sexual assault, childhood sexual abuse, and re-victimization (participants who experienced both child and adolescent sexual trauma). Within each of these groups, participants were mailed a packet of self-response questionnaires and given the option of completing a second phase interview with graduate psychology students. The questionnaires and interviews examined the impact of various types of sexual trauma on mental health, social adjustment, and sexual functioning. Their study concluded that those who experienced multiple episodes of sexual victimization had the greatest risk for negative mental health outcomes and increased risky-taking behavior. Furthermore, those who experienced even a single episode during adolescent were at the greatest risk for re-victimization, psychopathology, poor social adjustment, and risky sexual behaviors (Kaltman, et. al., 2005). Although this study offers a perspective of the lasting effects of sexual trauma, in relation to interpersonal and intrapersonal behavior, the study proves limited in terms of minority survivors and those without a college education.
The studies on male sexual abuse survivors remain rare. There is a tendency to restrict the issue of male sexual assault to environments such as prison (Rideau and Sinclair, 1982; Sagarin, 1976), the armed forces, or boarding schools (Goyer and Eddleman, 1984 as cited in Darves-Bornoz, Choquet, Ledoux, Gasquet, & Manfredi, 1998).

Within the research articles found for this study, the disorders and symptoms experienced by female sexual trauma survivors are almost identical to those experienced by male sexual trauma survivors. That is, men experience depression, dissociation, anxiety, somatization, relationship and sexual issues, denial, depression, lower self-esteem, shame, and guilt (Bruckner & Johnson, 1987). Other behavioral disorders like female sexual abuse survivors include substance abuse, eating disorders, and sexual risk-taking behaviors (PTSD.VA, 2011). One study by Marrow, Yager and Otnow (1997) also revealed that a percentage of boys who were sexually assaulted developed encopresis (bowel incontinence). Dimock’s (1988) study entitled “Adult Males Sexually Abused as Children” sought to determine the long-term effects of childhood sexual abuse on males who had been sexually abused as children and the common characteristics of this clinical population. Participants consisted of 25 adult Caucasian males aged 19 through 38. Data was collected via case records, clinical observations, and a questionnaire. Their study concluded the three common characteristics are sexual compulsiveness, masculine identity confusion, and relationship dysfunction. Examples of sexual compulsiveness exhibited by the test subjects were “a preoccupation with sexual thoughts, compulsive masturbation as often as four or five times a day—often to the point of injury—sexual acts with other men at pornographic book stores and restrooms, and frequent and multiple sex partners” (Dimock, 1988, p. 207).
Several studies pointed to gender socialization practices as the reason for different emotional reactions in males versus females. For example, Bruckner and Johnson (1987) observed that female survivors tend to internalize their emotions, whereas the male survivors were more outwardly aggressive and displayed more anger than depression. Their study consisted of a case study of two groups of male sexual abuse survivors, one with six men and the other with five men, and the common issues that arose during group treatment. These issues and characteristics were then compared to similar groups for women. Besides the difference in emotional symptomatology, Bruckner and Johnson (1987) also noted a difference in disclosure mannerisms in men versus women. For example, although the men were just as reluctant to attend a treatment group, once the men attended a group, they were more matter-of-fact in disclosing their sexual abuse history than the women, who often prolonged the disclosure to the point of anxiety. Furthermore, once the subjects had disclosed their abuse, they were more adamant about educating the public about sexual abuse and its effects, thus taking more control of their lives. This coincides with other action-oriented characteristics, in that once they made plans, either client driven or therapeutically driven, they often carried them out. Both men and women expressed a desire to confront their attacker; however, the men often carried out these plans (Bruckner & Johnson, 1987). This study offered several interesting clues and characteristics of male sexual abuse survivors, which have been documented in several other empirical studies found on the topic. However, their study does not include valuable evidence to support their comparisons to the women’s groups. Examples and quotations, while numerous of the men’s groups, were absent of the women’s groups, and therefore, the study’s conclusions cannot be solidified.
Several articles point to the gender roles that society has implemented as the direct cause for the aggression, confusion, and anger expressed by male sexual trauma survivors. McBride, (2011) and Winder (1996) both argued that men from early development are taught to be self-reliant and strong and to reject the qualities that define femininity such as vulnerability, openness, and emotional expressiveness. Furthermore, male sexual trauma survivors frequently experience “masculine identity confusion,” in which masculine confusion fell into two categories: confusion related to sexual preference and confusion related to male roles (Dimock, 1988). Survivors expressed that abuse caused by same-sex perpetrators caused confusion in survivors’ sexual orientation later in life, as well as feelings of failure in portraying the stereotypical masculine identity. As one subject exclaimed,

I do think I have some understanding of why I was a good candidate for abuse, but I think that deep down if I were a real man I should have been able to stop the abuse. It is hard for me as a male to tell people I was abused because I’m afraid they’ll say I’m gay or that I’m a wimp for being stupid enough to let some fag abuse me. There is a part of me that keeps telling myself that I’m gay or a wimp because I let some asshole touch me.

(Dimock, 1988, p. 209-210)

In an effort to “prove” their masculinity, male sexual trauma survivors often engage in hyper-masculine and/or self-destructive behavior (PTSD, 2011, McBride, 2011). Most male sexual trauma survivors question their sexuality and silence their abuse for fear of homosexual labeling by peers. Many boys erroneously believe that something about them attracts males and that this means that they are effeminate or homosexual. In retaliation of this belief, many male sexual trauma survivors have several female sexual partners or engage in sexually risky behavior, such as unprotected sex (McBride, 2011).
Although most perpetrators, for both male and female sexual trauma victims, are male (RAINN, 2012), it is a myth that male sexual trauma survivors will eventually become perpetrators themselves. This myth called the “Vampire Syndrome” creates a terrible assumption that boys that were abused would go on to “bite” or sexually abuse others. However, research from Jane Gilgun, Judith Becker, and John Hunter (as cited in Male Survivor, 2007) on this myth points to the importance of therapy for male sexual trauma survivors. Their research states that while a large percentage of sexual perpetrators were sexually abused, not all sexually abused males perpetrated. Furthermore, those non-perpetrators received counseling and therapy and were believed and supported by significant figures in their lives (Male Survivor.com, 2007).

There is an abundance of myths about male sexual trauma survivors, and most are attributed to gender socialization practices and the concepts of masculinity and femininity in mainstream society. In “Gender Matters: Working with Adult Male Survivors of Trauma” Mejia (2005) postulated that the most effective treatment for male sexual trauma survivors is derived from the very movement that often villainizes men: the feminist movement, and more specifically feminist theory. “Feminist theory proposes that nonhierarchical egalitarian relationships should exist in human interaction and in institutional settings” (Mejia, 2005). Mejia also stated that the best treatment for male sexual trauma survivors would encompass a facilitation of gender-role analysis and redefining masculinity in relation to themselves and their trauma.

After reviewing the research, only two articles directly compared the symptomatology and behavioral responses in male sexual trauma survivors versus female sexual trauma survivors. These articles provided similar results to the aforementioned literature. The first study, conducted by Darves-Bornoz, Choquet, Ledoux, Gasquet & Manfredi (1998) studied
questionnaires from 14,278 school-age French adolescents to determine the socio-demographic characteristics and medico-psychological and behavioral problems of sexual trauma survivors. Of these students, 465 reported sexual assault, with 121 boys and 344 girls. Their findings concluded that although girls were more often sexually assaulted than boys, boy victims tended to be younger in age than girls and exhibit more frequent behavioral symptoms, such as repeated suicide attempts, running away, fits of violence, and substance abuse. Girls, in comparison, were more prone to medico-psychological complaints such as nightmares, multiple somatic complaints, and mood disorders. However, this study only compared the results of school attending victims, and the study reports that there may be a discrepancy in the correct ratios due to the propensity of boy victims to leave the school system.

The other article that compared the gender differences in prevalence of, and reactions to, sexual trauma offered similar results for adult sexual trauma survivors. In this article, Elliott, Mok and Briere (2004) conducted a stratified random sample of 1,442 individuals. Of these individuals, 941 testified to a sexual assault history and were chosen to participate in the study. Within the 941 participants, the slight majority were women (50.2%), Caucasian (74.4%), and lower socioeconomic status (modal family income of under $20,000). The mean age was 46 years. Conclusions were based on the Trauma Events Survey and the Traumatic Symptom Inventory (TSI). The study reported that men with a history of adult sexual trauma reported significantly higher levels of distress than female victims of adult sexual trauma on eight of the 10 TSI scales and equivalent levels on the remaining scales (Depression and Intrusive Experiences). They concluded that,

While assaulted men reported equivalent levels of depressed mood and posttraumatic intrusion as assaulted women, they reported greater difficulties in the self and sexual
domains. Furthermore, these men appear to respond to assault related distress by engaging in externalizing behavior and dysfunctional sexual behavior that direct away from painful internal states. (p. 209)

The study hypothesized that sexual-victimization may be especially traumatizing for men who are raised in a society that promotes men to be strong, aggressive, and avoidant of any (even forced) sexual contact with other men (Briere, 1996). However, the study also pointed to limitations similar to the French adolescent study in that the results are reliant on the self-reporting of those specific individuals and may not be relevant to the entire population.

**The Effects of Trauma on the Brain and Body**

In order to decipher how to treat sexual trauma, an investigation into how sexual trauma uniquely affects the brain, and subsequently the body, is needed. Although, there are numerous articles on the psychobiological effects of trauma on the brain and body, only a brief explanation will be offered for this literature review. These explanations will be provided by leading experts in the trauma field: Dr. Daniel Siegel, Dr. Peter Levine, Babette Rothschild, and Dr. Bessel van der Kolk.

An interesting look into how the brain works during trauma is investigated in the book, *Waking the Tiger* by Dr. Peter A. Levine (1997). In this book, Levine described the theory of the triune brain, comprised of three main parts: the reptilian brain, the mammalian brain, and the human brain. The reptilian brain, the part of the brain, which is most similar to animals and even reptiles, contains the brain stem and cerebellum and regulates the automatic survival instincts of the body such as flight-fight-and freeze. The mammalian brain contains the limbic system, including the hippocampus and the amygdala, and regulates the emotional self. Finally, the human brain contains the neo-cortex and regulates rational thought. Levine (1997) hypothesized
that since the same parts of the brain are activated within animals and humans during a potentially life-threatening event, studying certain animals’ reactions during trauma can lead to decreasing the possibility of developing traumatic symptoms. He further hypothesized that humans often second guess their survival instinct and delve too much into their rational or human brain, thereby resulting in a stagnation of the “freeze” response. When the energy does not dissipate within the reptilian brain and enters permanently into the higher brains of the mammalian and human brain, debilitating disorders such as PTSD are created (Levine, 1997).

Siegel (1999) concluded that trauma affects more complex and higher structures of the brain. Siegel wrote that high levels of stress, such as those that are experienced by sexual trauma survivors, dramatically affect both the hippocampus and amygdala areas of the brain. During stressful or traumatic events, stress hormones, or cortisol, flood the hippocampus and the amygdala, resulting in an over activated amygdala and blocked hippocampus. Excessive and chronic exposure to trauma and thus stress hormones, such as adults who are subjected to repeated sexual abuse, may lead to neuronal death in the hippocampus thus decreasing the volume of long-term explicit memory. Also during trauma, the victim may focus their attention on a non-traumatic aspect of their environment as a means to dissociate and escape the trauma. This divided attention from the traumatic event may lead to only the implicit encoding of the event. Therefore, the implicit emotional content of the trauma is remembered, whereas the explicit or reasoning content of the trauma is not.

Dr. Bessel van der Kolk’s (1994) article, “The Body Keeps Score: Memory and the Evolving Psychobiology of Posttraumatic Stress,” details the psychobiological effects of trauma on the brain and body. Van der Kolk wrote that trauma impacts the declarative memory (i.e. conscious recall of experience) or explicit memory—that survivors experience “speechless
terror,” in which “the emotional impact of the event may interfere with the capacity to capture the experience in words or symbols” (p. 258). Moreover, although traumatized persons can eventually have a fairly good psychosocial adjustment after trauma, stress often triggers irrelevant emergency behaviors and may often become re-traumatized by minor experiences.

Babette Rothschild (2000) continued van der Kolk’s (1994) discussion and research on the phenomenon of somatic memory in relation to trauma in her book, The Body Remembers. In this book, Rothschild remarked on the importance of understanding sensory memory, or the somatic sensations that are encoded into our body during an experience, such as, smells, sights, sounds, touches, tastes, movements, positions, behavioral sequences, and visceral reactions. The sensations are encoded into our implicit memory, or procedural or nondeclarative memory in which internal states are automatic. Traumatized individuals are often overrun by their implicit memory, in which they feel that the trauma is reoccurring. The overloading of implicit sensory memory often leads to flashbacks or dissociation from reality. Rothschild’s book delved into the importance of mental health professionals working with traumatized individuals on their body awareness so that the patients can to bring the implicit to explicit without overstepping their window of tolerance or their ability to maintain their homeostasis.

Survivors’ lack of body awareness could explain why they have more somatic complaints than non-traumatized individuals. Furthermore, the somatic complaints may cause sexual trauma survivors to seek medical care instead of psychological care. One study, conducted by Kimerling and Calhoun (1994), examined patterns of both physical and psychological effects of sexual assault and the roles of social support to determine whether victims would seek out medical care more often than non-victims. Their study compared 115 women ranging in age from 15 to 71 years, predominately African American, who had recently come to the Atlanta Rape Crisis
Center in Atlanta, Georgia with non-victim participants recruited from social service agencies and public housing projects. Using structured interviews, Kimerling and Calhoun determined that victims showed continued elevations of psychological distress throughout the year post-assault. However, their results indicated that despite these levels, victims did not seek psychological services with any great frequency than women who had not been assaulted. In comparison, medical treatment increased over the year post-assault. They hypothesized that victims’ somatization of the assault was interpreted as physical distress due to the fact that the majority of the complaints resembled physical symptoms of depression and anxiety, such as pounding heartbeats, headaches, nausea, and weight changes (Kimerling and Calhoun, 1994)

**Dance/Movement Therapy in the Treatment of Sexual Trauma**

Sexual trauma directly affects the body in the most intimate way with physical and mental scars. These scars often make the inner sensations of the body dangerous and foreign, resulting in the survivor feeling “a black hole of emptiness” (Valentine, 2007, p. 181). The guilt and shame associated with surviving sexual trauma also dramatically affects how survivors perceive the world and those around them. In compiling the aforementioned research on the effects of trauma on the brain and the body from Levine (1997), Seigel, (1999), van der Kolk, (1994), and Rothschild (2000) can lead to the opinion that verbal, insight-focused therapy that is centered in the pre-frontal lobe of the brain does not resolve traumatic events (Valentine, 2007). Furthermore, van der Kolk’s research points to traumatized individuals’ inability to process the trauma into words, which would deem traditional verbal therapy obsolete. As clients cannot access their voice to disclose their traumatized selves, the use of body-psychotherapy such as DMT provides a relevant alternative to traditional talk therapy.
DMT’s history alone points to its capabilities to treat trauma survivors. Beginning in the 1940s, DMT’s foremost pioneer Marian Chace treated traumatized veterans returning from WWII. She found that group movement interventions helped the veterans cope with “shell shock” now commonly known as PTSD and interpersonal connections (Valentine, 2007).

According to the Grace Valentine’s (2007) article, *Dance/Movement Therapy with Women Survivors of Sexual Abuse*:

Dance/movement therapy is a form of psychotherapy that uses the observation, analysis, and expression of human movement to bring about a change in overall functioning. Exploration and creative use of everyday movements and gestures, as well as verbal processing, help integrate the physical, emotional and cognitive aspects of the Self. (p. 182)

The integration of the body and the mind, combined with the unique capabilities of the dance/movement therapist to attune to the body of the survivor, help support the success of this psychotherapy (Valentine, 2007). Furthermore, DMT is inherently founded on the belief that the “body speaks” (Mills & Daniluk, 2002). In Rachel Vigier’s (1994) book, *Gestures of Genius: Women, Dance and the Body*, she explored the power of the “voice of the body—a voice inside the flesh” (p. 236) that offers a history of its wearer for which dance is the perfect medium in which to speak.

Although, there are numerous research articles and trauma experts’ testimonies that support the claim that body focused psychotherapy can be beneficial to treating sexual trauma survivors, there are unfortunately few articles on DMT’s effectiveness. From the few articles that are available, the majority of these articles only describe treatment with female sexual trauma survivors.
One such article is Jeanette MacDonald’s (2006) “Dancing with Demons: Dance Movement Therapy and Complex Post-Traumatic Stress Disorder,” a case study of a woman presenting with symptoms of complex post-traumatic stress disorder and her reaction DMT treatment. Another article is Mills and Daniluk’s (2002) qualitative study of five women sexual abuse survivors’ reactions to DMT. Also found was documentation of numerous case studies and anecdotal material provided by Grace E. Valentine’s (20007) and Bonnie Berstein (1995), which depicted DMT in individual and group therapy settings.

Within all of the articles, DMT was proven to be effective in treating the issues that commonly arise in sexual trauma survivors: guilt, shame, dissociation, sexuality, boundaries, intimacy and personal power (Berstein, 1995). Other qualities that emerged in group DMT sessions that helped survivors collectively cope were cohesion, expression, synchrony, rhythm, and integration (Valentine, 2007).

Unfortunately, after an extensive search, only one article was found that documented DMT towards the treatment of a male sexual trauma survivor. This article is Zvika Frank’s (1997) “Dance and Expressive Movement Therapy: An Effective Treatment for a Sexually Abused Man.” In this article, Frank remarked on the specific interventions and steps necessary for working on male sexual trauma survivors and documents each of the steps in reference to one case study. However, the treatment goals in this case study were almost identical to the goals with female sexual trauma survivors. They were “safety (self-confidence and trusting others), setting limits, accepting and re-ordering body image, expression of feelings, self-assertion, making contact with other people: socially and physically, and learning to deal with intimacy and sexuality” (Frank, 1997, p. 48).
A search on articles that directly correlated the two genders and their subsequent reactions to DMT resulted in an absence of literature. Therefore, this study will hopefully add to the literature available for gender comparisons for sexual trauma survivors in DMT treatment.

DMT often utilizes a vocabulary for describing movement and assessing the psychological needs of the clients based on Rudolf Laban’s codified movement qualities (Moore, 2012). Therefore, an investigation was conducted into whether or not there are codified movement quality differences between men and women. However, this search begot only one article. The article, Janet Kaylo’s (2009) “Anima and Animus Embodied: Jungian Gender and Laban Movement Analysis,” offers only a hypothetical explanation of gender specific movements within the context of Carl Jung’s Animus and Anima, Taoist yin and yang, and Laban’s fighting versus indulging Effort movement qualities. Within the article, feminine characteristics were correlated with the indulging Effort quality, “giving in,” and softness of yin and anima. Meanwhile, the fighting Effort quality, strong and direct characteristics of movement, were correlated with the masculine yang, and Animus. However, the article mentions Laban’s belief that an individual can possess both movement qualities regardless of his or her sex. Furthermore, this article does not discuss how psychological impacts and environmental changes or trauma affect the movement qualities of the anima and animus.

Lastly, the lack of research of DMT treatment with male sexual trauma survivors leads to the question of do males’ perceptions of dance hinder the ability to treat this sex with DMT? A search into men in DMT resulted in one article, which documented the responses of ten male dance/movement therapists during the 2010 American Dance Therapy Association International Panel (Capello, 2011). Within this article, the majority of the male therapists remarked on the common assumptions made by their male clients in that dance therapy and dance itself is too
“feminine.” Perhaps this misunderstanding further adds to the gender role confusion felt by some male sexual trauma survivors as previously described. As vulnerability to emotional expressivity are often present in dance therapy or dance, male sexual trauma survivors may feel apprehensive in being asked to exude such “feminine” attributes. They continued to say that male clients tend to have better rapport with male therapists, and the lack of male therapists could coincide with the reduced rate of male sexual trauma survivors seeking treatment in DMT. However, each therapist also discussed the importance of DMT treatment with both sexes. According to one therapist from Italy, “the creative process inherent in dance/movement therapy fosters integration of the less known or unrecognized parts of the self by experiencing feminine and masculine polarities” (Capello, 2011, p. 20).
Methods

Methodology

The methodology used for this study is a qualitative case study, in which data is collected via interview. Mertens (2005) provided a useful definition of a case study, pulled from the US General Accounting Office (1990): “A case study is a method for learning about a complex instance, based on a comprehensive understanding of that instance obtained by extensive descriptions and analysis of that instance taken as a whole and in its context” (p. 14). Descriptions and observations for this study will be gathered via the participant’s viewpoint in an interview format.

The research follows a constructivist paradigm due to the potential social implications and correlations within this study of men and women’s interpretation of dance. According to Mertens (2005) “one of the basic tenets of this theoretical paradigm… is that reality is socially constructed” (p. 12). Mertens continued, “Knowledge is socially constructed by people active in the research process and…researchers should attempt to understand the complex world of lived experience from the point of view of those who live it” (as cited in Schwandt, 2000, p. 13). Therefore, due to each therapist’s own unique responses to interventions, treatments and reactions, the constructivist viewpoint of data, which consists of multiple social constructions of meaning and knowledge, was the most conducive to this study (Mertens, 2005). Furthermore, Forinash (2004) claimed that, because constructivist qualitative research focuses on how individuals construct reality through their own experiences that they share with others, rather than an “absolute truth,” this methodology is the most effective means to understand the intricately personal and sensitive topic of trauma.
Participants

The participants within this study are dance/movement therapists who have or are still currently working with male and/or female survivors of sexual trauma. Therapists were recruited for the study via social networking: i.e. the American Dance Therapy Association forums and web boards, and the 2011 ADTA conference in Minneapolis, MN. Recruitment emails were also sent to alumni from the Dance/Movement Therapy and Counseling graduate program of Columbia College Chicago, who had previously expressed an interest in participating in future thesis studies. Requests for participants were sent with the anticipation of achieving a minimum of 10 and a maximum of 15 therapists to participate. When I first started this study, I did not expect to be confronted with the challenge of a lack of participants. Due to a limited amount of responding participants and time constraints, the amount of participants was lowered to six. I had also requested therapists who worked with, or had worked with, adult survivors of sexual trauma; however, after several months of searching for participants, the study was opened to therapists who worked with or had worked with survivors of all ages. Of these six participants, five were female therapists, and one was a male therapist. Five of the six therapists were currently working with survivors of sexual trauma. One therapist worked with child survivors, one with adolescent survivors, and four had worked with predominately adult survivors. Four therapists worked more exclusively with female survivors, one therapist with both male and female survivors, and one therapist worked predominately with male clients. All participants were shown and signed an informed consent form. A copy of the form can be found in Appendix A.
Procedure

Data was collected from therapists’ responses to separate structured interviews, which were recorded via a recording device and transcribed. The interview questions were structured around 11 specific questions; however, due to the personal and varied backgrounds of the thesis participants, questions were altered, or in some cases omitted, to accommodate each participant’s experience. Although a phone or face-to-face interview was strongly encouraged in order to preserve the integrity of each therapist’s statements, as well as garner enough information, one participant’s interview was conducted via Skype and recorded via a program named Evaer. Due to the sensitive nature of treatment and topic, and to protect their identity, therapists and clients are anonymous within this thesis. Pseudonyms were created for therapists and clients, and data collected was stored within password encrypted files. Furthermore, responses and reactions documented from the therapists were edited to preserve client/therapist anonymity. For the participants’ protection, copies of transcripts are only available upon request.

Data Analysis

Data was analyzed using a theme analysis approach described by Michele Forinash (2004) in Dance/Movement Therapists in Action: A Working Guide to Research Options. This approach was developed to best accommodate the specialized data and insight that emerges within creative therapy work. Forinash wrote, “In therapy, the uniqueness of the individual is valued and one is less interested in generalizing one’s individual journey in therapy to others” (p. 126). Following the guide created by Forinash, the analysis was conducted in three specific steps. The first is deconstruction, in which the data is thoroughly deconstructed and understood. Once this occurs, the information can be reconstructed, thereby uncovering new meanings and
awareness of the data. For this study, data was reconstructed through reading and rereading transcripts during which notes and insights were jotted down. Once I was fully immersed within the data, I began the second step of reviewing the data slowly and deliberately—calling attention to the specific phenomenon within each case study. I highlighted quotes and specific sections of the data and gleaned more meaning from each case study. Forinash (2004) emphasized that, within this step of the data analysis, the data be read during different times of the day and in different frames of mind so that conclusions are not quickly made and/or perceptions can be fully understood. This step proved to be necessary for me due to my personal relationship to the topic of sexual trauma—more on this in the Discussion section.

In the third and final step, I separated data into categories based on the data that was highlighted. Each category coincided with the each specific question within the eleven questions on the questionnaire. Within each category, I identified emerging and contrasting patterns of movement qualities and therapeutic themes. However, due to the differing variables of survivors and therapeutic environments, as well as the uniqueness of each case study disclosed by the therapists, generalizations of the population as a whole could not be concluded. Any overarching patterns within all groups of survivors described in the data are noted, and in some sections of the data, specific quotes to back these findings are present. Due to the individual nature of each case study, and within this type of qualitative data analysis, Forinash (2004) stressed that any correlation and connection between the case studies presented and outside case studies similar must be created by the reader.
Results

In this study, I had hoped to present findings garnered from dance/movement therapists on the challenges and benefits of using a body-based therapy on male and female survivors of sexual trauma, and how, or if, DMT can be a therapeutic intervention that facilitates recovery. Furthermore, this study hoped to illuminate whether gender socialization practices have an impact on how trauma is processed and emoted within the male and female bodies and how that impact is noted and observed by DMT practitioners. As discussed within the data analysis section, generalizations or collective “truths” could not be attained by the data due to the widely variable subjects; however, interesting and relevant observations are included. The results of each case study will be presented per participant in relation to each question within the questionnaire. For example, question number one will be followed by participant #1, participant #2, etc. For some questions, participants used one specific case study to disclose their observations, and in other questions, participants used several case study observations to make a general assessment. Whether the participant is referring to one specific case study or several will be noted at the beginning of the response. General themes, observations, and patterns follow the last participant’s response for each question.

1. What prompted your interest in working with these types of clients?

Participant #1: The participant did not expressively set out to focus on this population. She worked predominately with children and adolescents in foster care and social services. Through that experience, she encountered a lot of clients who had been exposed to trauma including sexual trauma.
Participant #2: The participant did not expressively focus on this topic; however, through her predominant work with children and adolescents, she was exposed to clients who often had sexual trauma listed in their biopsychosocial assessments.

Participant #3: The participant did not work expressively with sexual trauma survivors but with clients who were being treated for substance abuse. A wide percentage of these clients also had a history of sexual abuse or trauma. In her experience at her therapeutic site, sexual trauma was explicitly disclosed by female clients, as well as written in their biopsychosocial assessments. She speculated that some males at the site had a history of sexual trauma, due to their implicit reactions in group therapy, but clients had not disclosed abuse explicitly.

Participant #4: The participant had a more direct experience with sexual trauma survivors. She interned—through the Dance/Movement Therapy and Counseling Department at Columbia College Chicago—at a sexual assault center in a suburb of Chicago. At her internship site, she worked with incarcerated mothers and children in foster care who were exposed to sexual trauma. She was currently working with male and female veterans, whom she had reason to believe—either explicitly or implicitly disclosed in group sessions—experienced military sexual trauma (MST).

Participant #5: The participant worked at an inpatient psychiatric hospital for several years where he was exposed to clients that had a history of sexual abuse. He later attended a conference in New York where a male friend and a male acquaintance disclosed his own sexual trauma and suggested that the participant work with him and other male survivors. He started his own group as a result, and while researching therapeutic techniques and case studies on male sexual trauma survivors, discovered a tremendous lack of literature and research on that specific
population. As a result, he created a four stage treatment model, which he uses today in his individual and group therapy. The treatment model was based on research available on case studies of women and children with sexual trauma and was specifically adapted for male survivors. He emphasized the importance of male therapists, such as himself, working with male survivors, so that the male survivors could see that it is acceptable for a male to dance and be in a therapeutic process. He summarized clients’ reasoning, stating: “men don’t dance; men play football; men are more into sports; [there are] all these clichés that men who are dancing…are gay.” Therefore, while working with his clients, he focused a lot of his work on expanding their body awareness of movement, then used primarily for physical fitness, to include movement for a creative and/or therapeutic aspect. He also explained that it is beneficial for clients to also have a female therapist in the session to give support or accepting reactions to those clients’ who may feel betrayed by female figures, such as their mothers.

Participant #6: The participant did not expressively work with sexual trauma survivors; however, her case load often exposed her to clients, both male and female, who had a history of sexual trauma.

Themes and observations: All participants fell into working with this population through happenstance. Even those participants who currently worked with sexual trauma survivors exclusively did not set out to work with those clients. However, regardless of the site, participants were exposed to both male and female survivors of sexual trauma.

2. Describe your clinical setting and how many years you have been working with survivors of sexual trauma.
**Participant #1:** She was currently working with children and adolescents in foster care or social services. She was in the field for six years, four of which she had more direct exposure working with survivors of sexual trauma (while she was working at an outpatient rehabilitation center for children and adolescents). However, due to their short stay, she did not feel she was able to work intensively with them. She gathered from her work experience that most, if not all, of her clients, who were wards of the state or in foster care, had some sort of traumatic history. She was currently working with home based care and through out-patient facilities, going to homes or schools or to different offices predetermined by the organization.

**Participant #2:** She worked for nine months at a long term residential treatment facility (average stay of client of two years). The two case studies she presented for the study were two clients to whom she was assigned and with which she worked on an individual basis. She worked individually one time per week for 30 minutes with the younger client and 45 minutes with the older client. The sessions were held in the younger client’s room, which inevitably posed some distraction issues for the client, whereas the older client’s sessions were in the DMT room.

**Participant #3:** She worked at her current site of employment—an in-patient substance abuse center—for 14½ years. Her department specialized in recreational therapy, leisure education, DMT, creative arts therapies, etc. Adjunctive services to individual and group therapies were already offered at site. Depending on clients’ needs, she met with them two-four times a week. Clients had one exercise group a week, followed by DMT/Creative Arts therapy groups or outings the rest of the week. She worked with two female units, one male unit and one co-ed unit, which was the detoxification unit.
Participant #4: She was working for two years at a social services facility that helps veterans assimilate into current society. She predominately worked with veteran support groups where she led male only, female only, and co-ed groups. Of her clients, most could not receive treatment at local VA hospitals due to—according to clients—a lack of resources for trauma support groups, especially those for women veterans. For this study, she described more of the sexual assault trauma center that she attended as an intern for one year. There, she worked closely with females who were being treated for sexual assault and/or domestic violence. She recalled a very safe therapeutic out-patient setting, which had two houses—one of which was for those being treated solely for sexual trauma and the other for domestic violence. In the center there were therapeutic rooms for just the clients, play rooms for the clients’ children, a group room for the clients, and a small office for individual therapy. Clients were referred there from a hotline that they called, a loved one requesting services, or they were referred from medical or legal advocates after the client went to an emergency room following a sexual assault.

Participant #5: He worked at a psychiatric hospital for 28 years with “all kinds of clients,” until persuaded by a male personal friend and a male acquaintance to create a small out-patient group with male sexual trauma survivors. After that, the participant worked more exclusively with male trauma survivors, which he worked with for six months, 3 hours per week. Besides group sessions, he stated that clients were required to seek outside help at an in-patient facility if need be and consultation from a psychiatrist. Clients were also encouraged to invite their families to open houses to witness clients’ creative work (dances, drawings, writing, or poems).

Participant #6: She was currently working at an in-patient psychiatric hospital in a low socioeconomic status area of Chicago. The hospital had four behavioral health units; two units—one male, one female—were for medical/psychiatric clients with serious psychological issues in
conjunction with medical issues. These two units were mainly for more violent clients, so for the clients’ safety, they separated the two sexes. Other units were mixed or co-ed, and contained some clients with psychotic issues but mostly mood disorders. The clients were acute cases and were short-term stay (average stay of four days, longer two weeks). However, the recidivist rate was high as most were forensic clients (had a criminal background and were awaiting trial for competency), had substance abuse problems, and lived in high-crime neighborhoods where there was little to no continuation of care.

*Themes and observations:* All of the participants described different environments in which treatment was conducted. These several different therapeutic settings included out-patient and in-patient, in-home or organizationally run, long and short term. Also participants included both acute and chronic clients.

3. **What are the demographics in general terms (gender identity, race and age) of your clients?**

*Participant #1:* Clients were 15 to 20 years of age, female, and predominately African American, although there were a few Caucasian and one Hispanic client. A few of her clients identified as lesbian or bi-sexual. In reference to her experience at the outpatient rehabilitation center for foster care youth, she used two case studies in this study for her experience with male survivors. In these two case studies, she worked with two adolescent boys, one African-American and one African.

*Participant #2:* Both clients were African-American female, one age 11, the other age 15.

*Participant #3:* Clients the participant focused her response primarily on were 80% African American, 15% Hispanic, and 5% Caucasian females. The median age was 38-39, and clients
were predominately between 30-50 years of age. Most clients were recidivists and had been “in the system” for decades.

*Participant #4:* The participant used case studies from two sites. However, the participant primarily focused her responses on the sexual assault center where the population was predominately female—about half Caucasian and half Hispanic, with a small percentage of African-American clients (2%). Their ages ranged from nine to 65 years of age. She pulled case studies and examples from her current site, which had a population of both male and female military veterans, aged 30-55 years, predominately African-American with a few Caucasian clients.

*Participant #5:* The participant focused responses on case studies and examples from his male group comprised of predominately Caucasian males between the ages of 35-45 years, all with different socioeconomic and education statuses. The few female client examples were from a psychiatric hospital, were predominately Caucasian, and were between the ages of 18 and 35 years.

*Participant #6:* The participant’s working population was predominately African-American, roughly 97%. They were mostly men, 25 to 50 years of age. All clients were in the low socioeconomic status bracket.

Themes and observations: The population depended on the environment and treatment site; however, the most prevalent ethnicities were African-American or Caucasian. Clients were mostly between the ages of 25 to 50 in male survivors and 10 to 35 in female survivors. Clients had varying degrees of socioeconomic statuses, education levels, and military/non-military statuses.
4. What, if any, was the initial presenting problem for the clients?

Participant #1: Clients were referred to her by social services for processing other past traumas including neglect, abandonment, physical abuse, sexual abuse, witnessing violence i.e.; PTSD or Complex PTSD. Other presenting problems included anger management, grief and loss recovery, as well as specific mental illnesses including Major Depression, Bi-Polar, Social Defiant Disorder, and Conduct Disorder. Some clients also were treated for substance abuse, most commonly marijuana and/or alcohol. Some clients also displayed risky sexual behaviors and promiscuity.

Participant #2: For the case of the 15 year old female, she was being treated for her history of running away from biological and foster families, self-harm, and sexual abuse by her stepfather. For the 11 year old female case study, she was being treated for her history of child sexual assault by her mother’s boyfriend.

Participant #3: Clients were predominately being treated for substance abuse, often chronic; heroin was the most common substance. Some clients were also treated for MISA—or mentally ill substance abuse; common illnesses were Bi-Polar, Major Depression, and Schizophrenia, either generalized or Schizoaffective.

Participant #4: The participant responded for two different sites. For clients at the sexual abuse center, the initial presenting problem was domestic violence, alcoholism, and sexual abuse. One case included a pain disorder linked to sexual trauma, and one case included a Traumatic Brain Injury linked to another abuse incidence. For clients at the military center, the initial presenting problem was often homelessness and difficulty re-entering into society after military service. This included a desire for help finding resources for food, shelter, jobs, clothing, etc. Some
presenting problems also included suicidal ideation, PTSD, and alcoholism. Clients were not referred to, or treated at, the center for mental health services but were encouraged to attend mental health “enhancements”.

Participant #5: The participant described two separate types of clients—those that knew of the group and directly requested sexual trauma treatment, and those referred to him and his group from addiction centers or psychiatric hospitals where they were treated for mental illnesses, such as Major Depression. He currently had a group of four sexual trauma clients. Two of the clients’ trauma resulted from familial rape, one from a church superior, and one from outside or stranger rape. However, historically, the clients were survivors from a variety of sexual trauma circumstances. In percentages, 30% were survivors of familial or incestuous rape, and 65% were survivors of outside/stranger rape. Most clients were between the ages of 8-16 years of age for the onset incidence. Most of the female clients he treated had Borderline Personality Disorder and Major Depression Disorder.

Although not an initial presenting problem, this participant also noted promiscuity in women. Before their treatment, the women would walk in a provocative fashion and wear sexy clothes. He stated, “They are taught of attention by sexuality… some think that if ‘I give my body away, I will get attention.’” For his male clients, a common male coping mechanism would be self-mutilation by way of compulsive and frequent masturbation, often to the point of injury. He stated, “One client was 12 times a day, and it’s nothing with sexuality… if they masturbate, then they don’t think about the pain.” Also, there is an interesting dichotomy between the male clients who present themselves as very clean, organized, and create an appearance that there is “nothing wrong with us” versus those that have a lot of tattoos and do not care as much for the body. The participant described the tattooed clients as wanting to be feared or portray a
menacing persona to the outside world. The participant also noted that he would not be able to treat perpetrators.

Participant #6: A few clients were forensic clients—or those being treated and determined to be fit for trial for criminal offenses. In percentages, clients were roughly 80% Schizophrenic or Schizoaffective disorder, 15% Bi-Polar, and 5% Major Depression. Most clients had a history of substance abuse, commonly alcohol, heroin, and crack cocaine. In response to the question “When talking to these clients about sexual trauma, do they talk about how addiction has tied in with it?” participant 6 responded, “Yeah, they do! They talk about how it’s one of the things that has changed them and that’s one of the ways they self-medicate when it comes up… not wanting to be in their body, not wanting to feel really.” This demonstrates that childhood sexual trauma could trigger substance abuse.

Themes and observations: The responses showed a wide range of mental health illnesses, such as Major Depression, Bi-Polar, and Schizophrenia as initial presenting problems. Some of the more common themes within all clients were anger management, substance abuse, self-harm (in the form of cutting or compulsive, often injurious, masturbation), promiscuity, risky sexual behaviors, depression, and PTSD.

5. If working with men and women clients, what, if any are the differences in presenting problems between men and women?

Participant #1: In male clients, the participant identified more aggression, Bi-Polar disorder, and anger management issues. The participant stated there was some aggression in girls, but males seemed to channel their aggression more outwardly. In one example, she relayed a case study of a male client from Africa, who was exposed to several traumatic war crimes as well as sexual
abuse from his father. The participant discovered, “He needed to be in a state of chaos and hyper-arousal to feel normal. He would surround himself with gang members, but he would say, ‘I’m not in a gang.’ It was like that violent potential, like he was running from police, or whatever it would take to get to the next aroused state.” For the other adolescent boy whom she treated, the focus was on discouraging fighting and refocusing anger. Her intervention tactics predominately focused on modulation, as this participant client was also a perpetrator. The participant also expressed that besides this one case, she would find difficulty working with perpetrators.

*Participant #2:* The participant only worked with female clients so could not contribute to this question.

*Participant #3:* The participant only discussed female clients; however, the participant did note that most of the male clients were ex-convicts, had been in a penitentiary, and had a prominent aversion to some movements. The participant hypothesized that some had been survivors of sexual assault. More examples and discussion on this will be addressed in question 10.

*Participant #4:* The participant focused her responses predominately on case studies of female clients in the sexual assault center, so the participant was unable to provide a response for this question.

*Participant #5:* The participant did not directly point to differences between male and female clients; however, the participant did describe female clients as having more Borderline Personality Disorder and promiscuity, whereas, male clients would often self-harm in the fashion of frequent and injurious masturbation.
Participant #6: The participant noted a similarity in substance abuse for both male and female clients due to the nature of the center, the prevalence of drugs and alcohol in their community, and the lack of community outreach and supportive services. When comparing female and male clients, she observed that women tend to use internal coping mechanisms, such as self-harm or “cutting,” display more Borderline Personality Disorders, and have more recurrent suicidal ideation. In comparison, male clients tended to externalize their feelings. She stated, “Men who have been perpetrated sexually tend to be perpetrators themselves more often than the women, especially the ones who had experienced it in childhood.” The two case studies she remembered of male clients who had a history of childhood sexual trauma became pedophiles themselves. She added, “…The men go out; they inflict (pain) on others, whereas the women, tend to more often inflict (pain) on themselves.”

Themes and observations: This question more often than not tended to be obsolete for most participants in that it either re-asked the same question as number three, or was unnecessary due to the participant only able to contribute a female client perspective for the study. However, some new and interesting information was gleaned from participants who had some experience working with both male and female sexual trauma survivors. For participants one, five and six who contributed information on the differences in male versus female survivors, the differences were that male survivors reacted externally to their trauma, which manifested in aggressive behavior, poor anger management, and becoming perpetrators themselves. Male survivors were also more self-injurious in the form of compulsive and aggressive masturbation. In contrast, female survivors displayed more internally destructive behavior as manifested by suicidal ideation, self-harm in the form of cutting, promiscuity, and Borderline Personality Disorder—a
client who displays unstable impulse control, interpersonal relationships, moods, and self-image (Morrison, 1995).

6. When during treatment were you able to focus solely on the sexual trauma? Or if not, why were you unable to focus solely on the sexual trauma?

Participant #1: The participant focused her responses on one specific case study of an 18 year old African-American female, who had been sexually abused by father for 8 years and gave birth to a son as a result of the incest. The participant focused her treatment solely on recovery from the client’s sexual trauma and recovery.

Participant #2: The participant did not focus solely on sexual trauma with her clients but rather the factors and challenges of living in a long-term residential treatment facility. The participant did not feel she could work solely on sexual trauma because she focused more on presenting challenges and problems that came up during the week. She was also aware that the clients were in many other forms of therapy, so she did not “think [she] always had the opportunity to address or treat it.” Instead, she focused more on boundary work, establishing healthy relationships, and expanding clients’ window of tolerance—the “area in which various intensities of emotional arousal can be processed without disrupting the functioning of the system” (Siegal, 1999, p. 253). She stated she worked on, “Being able to express their feelings without, for the girl who cut herself, without harming herself. The other girl was very aggressive so without punching someone in the face if they sat next to her, things to that.” The participant disclosed that she only learned of the younger client’s sexual trauma history because it was written in her biopsychosocial assessment. Like her older client, the participant read about the history in her biopsychosocial assessment; however, that client also verbally disclosed her history during a
session, in which the client was triggered into disclosing her history after speaking with her mother who triggered her flight coping mechanism.

**Participant #3:** The participant did not focus solely on trauma but on substance abuse, and only addressed the issue when it emerged in groups. When that happened, she would validate the client’s feelings but “defuse [and] de-escalate” the situation by taking focus off of the sexual trauma in group. She would mention that talking about trauma in their group therapy sessions was not group appropriate and redirect the client to their individual therapist.

The participant added that some groups trigger responses in reference to sexual trauma history more than others, such as DMT groups or her “Music, Feelings, and Expression” group. The participant was reminded of one case study in particular, in which one female client, who had a severe sexual familial trauma history resulting from three members of her family who shot her up with heroin to sexually assault her, was profoundly triggered by a specific song that was playing. The client responded by standing up from the table, banging on the table, and asking the participant, “Why? Why did they do this to me?” The participant stated that often times the other clients would go to the triggered client’s defense and validate and relate to that client by saying, “It’s okay, let it out” Or, “I understand; I was abused too.” In this instance, the participant’s response was to validate the client’s feelings and responses and redirect her to her individual therapist.

**Participant #4:** The participant described her two different sites separately. In regards to her work in the sexual abuse center, her focus on the client’s sexual trauma varied. At the site, therapists were given paperwork to be completed in the first few sessions; however, the center was client-centered, so therapists were encouraged to follow the client’s lead, so as not to re-
traumatize. The participant recounted one case study, in which the client disclosed all of her recent sexual assault history in the first session: “She needed to let someone know that this happened.” The participant did not focus solely on the sexual trauma in therapy; she focused on the repercussions and instability that resulted from the sexual assault and on helping “them function normally in their daily lives.” For example, when working with a client who had a history of childhood sexual trauma from her mother and uncle, the therapist addressed anger management, difficulty establishing lasting relationships, fear of intimacy, need to isolate, and suppressed anger towards the client’s father who had left the family. The participant often took cues from her clients and followed a more client centered approach. These cues were movement cues, such as held breath, rapid speech, and anxiety responses, which helped her assess whether the client was dissociating or going out of their window of tolerance.

*Participant #5:* The participant’s work focused primarily on the treatment of sexual trauma and recovery. The participant created his own four stage treatment philosophy, which was based on Albert Pesso’s five basic needs principle as well as research he had gathered from female and child sexual abuse case studies. Further research revealed that Albert Pesso and Diane Boyden’s therapeutic method is called the “Pesso Boyden System Psychomotor.” Boyden and Pesso developed this system based on their collective experiences as dancers and choreographers, during which they noticed that feelings were expressed physically (Williamsen, n.d). From this observation, they uncovered five basic patterns of human development: place, nurturance, support, protection and limits. The therapeutic system focuses on healing past “emotional deficits” using a process called “Structures” and “Microtracking” that helps clients identify emotional deficits and create new memories via emotional reprogramming (Pesso Boyden Psychomotor System, 2012).
In the participant’s therapeutic work, within the first stage, the emphasis was on safety and could take a long time because “people who were abused...feel very unsafe and very insecure.” In this stage, he encouraged small introductions of movement, such as one finger, or one eyebrow, as there was often poor movement vocabulary in his male clients. The sessions begun in a Chacian circle (derived from the Chace technique created by Marian Chace that uses dance movement as its “predominant mode of interaction, communication and expression” (Levy, 2005, p. 23). The Chacian system is comprised of three sections that have their own style of intervention and purpose: the beginning (warm-up), middle (theme development) and end (closure). In the context of this participant’s therapy, movement was more aerobic or resembled “gym movement.” Also, within the safety stage, he worked to establish boundaries with the clients themselves, the group as a whole, and the therapists. He explained that clients needed to know that the therapists could provide safety but that they could also protect themselves in the therapeutic setting.

The second stage was the fighting stage. In this stage, the group started with a warm-up and a Chacian circle. Then he slowed the rhythm and introduced new movement to include the lower part of the body and stomach. The participant stated, “The first time that I [had] them move their hips, they [choked] because it always gets associated with sexuality... We also [talked] about how sexuality is very normal because for them it is abnormal.” Also during the warm up, he gradually added movements that embodied strong weight, or increasing pressure, and directing. These effort qualities constitute the fighting elements of Weight and Space motion factors (see Key Terms in the Introduction for definitions). After the end of the second or even first stage, the group became a closed group, and new members were prohibited.
In the third stage, the participant brought in more body awareness. As he stated, “The body language. What does your body say? And you start to work with someone on softness, and indulgent with how everything is very quiet and slowly, slowly, when really very conscious, to touch your own body, to be touched and to touch.” Gentle or affectionate touch was also introduced during this stage via partner work that had begun in the first stage wherein touch was approached more functionally, such as in handshakes. Another aspect of the third stage was the introduction of Authentic Movement—or an expressive improvisational movement practice that incorporates moving with images and imagery (Levy, 2005). In this stage, clients showed a more stable approach to movement; they were in the body rather than surrendering to traumatic memories and an aroused autonomic nervous system. The participant stated, “the body can do… things without (the) head working, and you hear from them at the completion that, ‘Wow! The body is really different from the head!’” During Authentic Movement, he encouraged clients to begin witnessing other clients so that they had the experience of one being the mover and the other the witness. Occasionally, the witness also joined the mover. Also only in the third stage did the participant allow the clients to explicitly recall their sexual trauma and how it impacted their life. Clients were asked to write down their entire life history, including the traumatic experience, within half a month’s time. The participant stated that this is often the first time that he is able to become aware of their entire traumatic history, as most clients do not explicitly share their trauma even when given the opportunity. In the fourth and final stage, the treatment is terminated, and the participant prepares the client for separating from the therapist and the therapy.

Participant #6: The participant did not focus solely on sexual trauma in her treatment but rather addressed the issue on an as needed basis—when it came up in group or an individual session.
when a memory had been triggered. The participant relayed a specific case study in which one woman went out of her window of tolerance after a male client described a betrayal of trust by a family member. The female client viscerally reacted with a crying outburst and was unable to come back into her window of tolerance. In this case the male client was able to support the female client by saying, “It’s going to be okay.” Even so, the client had to leave the session so that she could work with her individual therapist and regulate.

*Themes and observations:* The therapeutic setting for each participant was a deciding factor on if and when the participants were able to focus on clients’ sexual trauma history. Some, such as Participant three and six, felt more comfortable not focusing on the sexual trauma; instead, if it emerged in groups, they defused and redirected the focus to another topic and/or referred the triggered client to their primary individual therapist. Participant three and six also were encouraged by their supervisors to follow this “rerouting” protocol.

After reviewing the transcripts it became apparent that an inclusion of a separate category that described the participants’ preferred DMT style was needed to help clarify their responses to questions #7 and #8.

*Participant #1:* The participant used a client-centered Chacian method, with a specific focus on giving the client control over where and how soon sessions would progress.

*Participant #2:* The participant followed a traditional Chacian format, i.e.; warm-up, theme development, optional movement expansion, verbal processing, and cool-down. Depending on the day and the clients’ needs, the participant introduced improvisation or a transitional object or prop, all within the umbrella of a client-centered approach.
Participant #3: The participant used the Chacian method, and sometimes incorporated social dancing, such as salsa dancing.

Participant #4: The participant used the Chacian method during group therapy at both sites. However, at the sexual assault center, where she had individual therapy sessions, she incorporated play therapy, the stability or dimensional scale (i.e., moving through all dimensions of the kinesphere—see question nine for definition), guided imagery, and guided movement. If the client was familiar, she sometimes used social dances, such as the Cuban Shuffle, to encourage movement. The participant also discussed an affinity for voice work and a desire to establish and research DMT and the inclusion of voice while working with sexual trauma survivors.

Participant #5: The participant used the Chacian method, authentic movement, and the participant’s own four stage treatment model based on Pesso Boyden System Psychomotor therapy.

Participant #6: The participant used a Chacian method with an emphasis on grounding, or stabilizing the self, and rhythm.

Themes and observations: All participants used the Chacian method and a client centered therapeutic approach with individually specialized interventions.

7. What, if any, types of DMT interventions do you not practice with these types of clients?

Participant #1: This question was answered using a case study. Following her client-centered approach, the participant was mindful of allowing the client control—in her movements and in where the session went—to limit re-traumatizing. Therefore, the participant did not try to control
or lead the sessions but allowed the client to direct. The participant identified that control was an important issue for this case study, as the client often had control taken away from her either via her sexually abusive father or later from her “controlling- dictatorish- foster mother.” In relation to the one case study, as well as other clients, the participant was wary of touch, especially while working with adolescents and children. The participant felt that touch could induce countertransference—or the emotional feelings of the therapist placed upon the client—and could promote poor boundaries.

Participant #2: The participant did not notate specific interventions that she would not use. However, she noted that she tried to promote a safe, healthy environment for clients, keeping boundaries in mind, especially while working with children and level changes to the floor. If the client wanted to lie or sit on the floor, then the participant would continuously check in with the client to determine homeostasis.

Participant #3: The participant did not try to focus on the trauma or probe into case histories while in group therapy sessions. The participant was also mindful, especially when working with MISA clients, not to steer movement toward the hips or anything in the lower body during groups. However, this participant shared an anecdote in question eight, in which positive processing emerged from locomotion of the hips. For this reason, she would use moving the hips and lower body in the Chacian warm-up but not focus the entire group on the lower body.

Participant #4: The participant determined what was and wasn’t used depending on the needs of the client. For example, one client, who was eleven was sexually abused by her brother, was actively engaged in play-oriented therapy; however, the participant could not stand in front of her or directly engage in play with her as it was too triggering and intimate for her. Movement
for this client was very difficult, and the participant was mindful of not introducing certain movement, such as yoga poses, that would resemble sexual movements or poses her brother forced upon her.

Participant #5: The participant did not do anything with a sexual trauma survivor client that he would not do with any other type of population: “I think it is how in reality; the more free the movement in the body is, it is better for the body. The body is hurt; the body needs to be treated.” However, the participant disclosed that he often did not encourage females to level change to the floor as “most women do not like to go to the floor anyway because it is too dirty.” However, the participant was adamant about taking an extended amount of time to process the trauma with clients and did not encourage clients to reveal their traumatic history until the third stage of treatment.

Participant #6: The participant did not bring up memories of trauma but tried to keep patients in the present moment due to their acute state. In addition, most were already at an elevated level of anxiety. The participant relayed that if patients are brought into a traumatic memory while they are already elevated, it could trigger a more severe bodily response, such as seizures. The participant was also mindful of using imagery, making sure the client was in a safe mindset before she attempted to move out of the present space and into imaginary thinking.

Themes and observations: Participants always focused their interventions and movement styles to accommodate the client and their specific needs. Special care was also given to the environment and the client’s ability to delve into more deep-seated traumas and wounds. However, the common patterns that emerged were (a) an aversion to focusing solely on trauma itself (if participants were in an environment that focused on treating another presenting problem,
such as substance abuse, or acute suicidal or homicidal ideation), (b) an aversion to touch (especially with boundary sensitive adolescents and children), and (c) an aversion to focusing on movement in the lower half of the body with specific populations, such as MISA.

8. What was your most successful DMT intervention?

*Participant #1:* The participant used one case study to describe her most successful intervention. While working with a nineteen year old, African American female, who was a survivor of childhood sexual trauma, she focused on encouraging the client to find self-empowerment and control to prevent any further re-victimization either in relation to trauma or being manipulated interpersonally. The participant set out to work with the client in finding where the word “No” lived in her body. She began with Rena Kornblum’s spatial needs game, “Approach and Stop” wherein the objective is to “increase awareness of early warning signs and awareness of differences in people’s spatial needs; respect for those differences; body awareness; awareness of feelings” (Kornblum, 2002, p. 23). In the exercise, one person, the “boss,” stands a few feet away from another, the “mover.” The mover gradually walks toward the boss who is standing with either his/her back to or facing the mover. The boss’s role is to say STOP when he or she feels uncomfortable or experience bodily cues that the mover is too close. The mover’s job is to respect that command, as well as note the bodily cues the “boss” is exhibiting. The participant relayed that this simple game was challenging for the client at first, even with the participant’s slow and mindful approach, but by encouraging the client to increase pressure/weight in her body and in her voice, the client was able to gain more confidence. In the beginning of the intervention, the client indicated that “No” lived in the throat area. As the intervention progressed, the “No” became firmer, and the client exuded more confidence; the “No” progressed down to her core or naval center and finally spread out to include the entire space.
between her chin and hips. The participant altered the approaches to include fast walks or not stopping when the client said “No” to give the client difference scenarios or variables in the intervention. The movement between the client and the participant gradually became an “almost choreographed warrior dance motif of movement”—the “Warrior” being what the client described herself as while doing the movement. In processing, the participant paraphrased the client’s statements by stating that the client disclosed she “felt powerful, but I don’t want to be the warrior.” The participant asked what she wanted to be, and the client responded, “The Queen.” The participant then worked with the client to determine how the client could be the “Warrior” and the “Queen.” The participant stated that this intervention was conducted at the beginning of their work together but provided a sound and safe theme that both the client and therapist could relate to and continue to hone.

Participant #2: The participant provided interventions and examples from two case studies, one an 11 year old, African-American female, and the other a 15 year old, African-American female. In regards to the eleven year old, the client requested a Hula Hoop. While hula hooping, the participant saw the client’s movements become more sexual, which provided a lot of insight and ideas to work on in the future. The sexualized movement that she felt the client was exhibiting included lowered eyes, puckered lips, a dazed affect, and occasional hip thrusts. In response, the participant worked on modulating the client’s movements to include smaller or bigger circles. The participant reported that the client was not able to explicitly process the sexualized movements due to the therapeutic setting and/or the client’s reluctance to discuss and process the trauma. However, she described several other interventions that helped or guided both clients in establishing healthy relationships, boundaries, and grounding—such as introducing the use of weight thus increasing the comfort level in grounding, or getting into the lower part of their body
so that the clients would not resort to their common reaction of fight or flight. The participant also emphasized utilizing interventions in which she met clients where they were currently at, and reinforced clients’ autonomy during movement sessions: “So much of their life was already controlled for them, so even little things like whether we used the ball or the drum was up to them.”

*Participant #3:* The participant stated that there was not a specific movement intervention that she used because her style was more Chacian and “going with the moment.” However, when a client was triggered or brought up sexual trauma in processing, she validated his/her response and utilized reflective listening but did not encourage the client to elaborate or delve deeper into his/her traumatic history. The participant stated that often when one client is triggered or explicitly recounts his/her traumatic history, other patients help validate the client’s response and occasionally try to relate to the triggered client with their own traumatic history.

*Participant #4:* The participant used a variety of movement interventions, such as the stability scale, guided movement with colors throughout the body, or mirroring as a basis of engaging the client’s creativity to establish an inroad to gradually modulating the client’s movement to include more aggressive movements. The participant also encouraged the use of breath and voice with the clients. Although voice and the use of voice was very uncomfortable or challenging for some clients, those that were able to do the intervention felt empowered. The use of voice varied per client: some examples include encouraging the client to (a) vocalize what was happening in the movement, (b) express what was happening in his/her body, (c) sing the song that both participant and client were dancing to, or (d) create a statement to repeat or change while moving.
Participant #5: The participant used his four stage treatment, which was described in the participant’s response for question #6. The participant reported that at the conclusion of his treatment model, clients were able to dance together in group sessions using elements of touch, partner work, and level changes to the floor.

Participant #6: The participant described a few different interventions that she used when confronted with a client with a history of sexual trauma. She emphasized that it depended on the individual and what the individual was emoting. These interventions included helping clients feel safe in their bodies by moving to rhythmic songs or music, having clients dance with other clients, and encouraging clients to connect interpersonally in the therapeutic group while also keeping their attention on the present moment. Another technique she employed in order to keep clients in the present moment and space was to encourage sensory awareness, such inviting the clients to notice the smells of the room, the sights of the room, etc.—all under the umbrella of small or superficial acknowledgements and without going too deep into body and sensory awareness. The participant stated, “All that body stuff… all this stuckness in them and any kind of release with them is kind of scary, so you really have to take small steps.” In individual sessions, the participant also focused on establishing safety with the client as well as letting the client help determine the best intervention. For example, the participant used a case study of an adult, female patient with Borderline Personality Disorder with psychotic features who, during an individual session, regressed to the age when the trauma occurred. While in regression and in a dissociative state, the participant used the teddy bear that the patient carried around with her as a transitional object to promote a safe environment and sensory awareness for the patient so that she could come back into reality.
**Themes and observations:** Each intervention was individualized for each client and his/her needs to process his/her trauma. However, the majority of the interventions were based on increasing clients’ self-empowerment, assertiveness, and control. Also, most of these interventions were subjective in that case studies were recalled via the participants’ memories rather than through written documentation.

For question number nine, participants were encouraged to use Laban Movement Analysis (LMA) terms, a common language among dance/movement therapists. Most dance/movement therapists are trained to understand and/or use LMA to assess and treat clients. This study does not focus on the entire theory of LMA as to do so would be extraneous to the study and for the reader. However, a list of LMA terms can be found in the key terms section of this study for those readers unfamiliar with the method.

**9. What movement qualities (using LMA terms if possible) became most salient before, during, and after your time working with the clients?**

**Participant #1:** The participant focused on a specific case study of a 20 year old, African-American female. Before working with the client, the client expressed within the Body category a held upper torso, lack of breath support, and poor core-distal connectivity. Her Effort life was indirect, with an “absence of weight,” and rigid breath: “Tense, held in, not like free, like bound, bound, bound.” The client was often in Remote state—Space and Flow—with binding and indirecting. Her Shape category was a Screw shape, a preference for retreating in the sagittal plane, and a “tentative horizontal” plane.

Later in treatment, the client exhibited increased awareness of her upper/lower connectivity (saying “No” and indicating where it lived in the body) and more core-distal
awareness (Body). She accessed more directing, freeing, and increasing pressure (Effort). The client focused on accessing Vision Drive—Flow, Space, and Time: directing, freeing, and accelerating. She accessed the Mobile state more—Time and Flow, but the participant admitted that it “Could have been … my personal bias that I was seeing.” Within the Space category, she gained the ability to access, and grew more comfortable in, the vertical plane. The participant noticed a significant change in her assertiveness (being able to initiate what interventions they would use together) as well as a shift towards fuller body movements within chosen movement activities of “The Warrior” and “The Queen.”

Participant #2 The participant used both clients’ case studies to respond to the question. Before working with the clients, the participant noted that clients exhibited, within the Body category, held torsos, poor core-distal connectivity, and poor upper-lower connectivity expressed by an inability or resistance to access the lower half of their body and poor grounding capabilities. Clients exhibited passive weight in the Effort category and poor shaping in the body, most notably in the torso. Clients also possessed a small window of tolerance and a quick response into fight or flight.

After the participant introduced the use of weight and grounding into movement interventions, the participant noticed that clients had developed the ability to access their core-distal, upper-lower, and cross-lateral connectivities. The clients also exhibited an ability to use shaping within the spine, evidenced by an intervention in which the participant invited the clients to envision themselves walking through a crowd and knowing how to access their small or large kinesphere correctly while still moving and without causing injury to themselves or others.
Participant #3: The participant used two case studies and two DMT sessions to respond to the question: one Caucasian Female in her twenties being treated for substance abuse (first time client), and the other an African-American female in her forties with MISA in the spectrum of Major Depression (recidivist client). The participant observed the first client as bound and reserved in her lower body, staying in near kinesphere, decelerating, with no sense of weight. The client appeared very shy, quiet, and reserved, especially in regards to her sexual trauma history, which was only known at this time from her biopsychosocial assessment. During a DMT group warm-up, the participant encouraged the client to move her entire body, including her hips. In processing, when asked what part of the session she liked, the client remarked that moving her hips felt really good in that she was allowed to move them any way she wanted. After that group in which the participant validated the client’s experience, the participant noticed the client was able to move her hips more freely, and her movements as a whole became freer, with a fuller body integration, and her kinesphere extended more outward into a larger space: “After that group, after she got that validation of ‘It’s okay to feel that. It’s okay to feel sexual and feel sensual and to move that way’ her movement, her kinesphere, her use of space became… not like completely extended but larger.” The participant also reported that the client was able to be more direct in her speech and in her ability to express herself verbally. However, the participant also reported that although the client was more direct and comfortable in speaking, her body attitude was still closed and guarded with an emphasis on retreating.

In the second case study, the participant reported that the client was contrary to the first case study in that she would often talk about her sexual trauma freely, was easily excitable, and lacked proper boundaries. The client consistently expressed a need to verbalize and process her trauma with comments such as, “Why? Why did they do this to me?” Her movements were very
bound; she had a held torso. Her effort life was decelerating in her movement and in speech. The participant emphasized passive weight in the client by stating, “So weight-wise you’re 96 pounds, but you look like a rock.” In addition to decelerating speech, her speech was very scattered and indirect, which the participant attributed to the client’s MISA. During movement groups, this client would participate at the lowest level she could and seemed apprehensive in her movement. The participant remarked that this client was “very stuck” and had a high rate of recidivism. At the time of the interview, the participant reported that there had not been any change for this client as she was still apprehensive, and was extremely passive in weight.

Participant #4: The participant used generalities in all the case studies the participant worked with while at the sexual trauma center. Before treatment, the participant observed an affinity for bound flow, passive weight, a general resistance and discomfort with free flow, and an enclosed posture that would regress from bound flow to increasing pressure with retreating shape qualities. The client moved only in his/her near kinesphere and expressed a resistance to locomotion through space. There was also a resistance to directing in movements and eye contact. The participant would not say that the client was affined to indirecting but more space-less. The participant stated that clients were often in Dream state but also, for one particular client, in Remote state. Thus, during treatment, the participant focused on getting clients into Rhythm state by using music as an inroad to movement. The participant emphasized that getting the clients to move at all was a slow process, with clients often only engaging with small micro movements.

After treatment, the participant noticed more breath, core-distal connectivity, free flow and use of direct space, and a comfort in moving with fighting qualities. Clients enlarged their
kinesphere and expanded their reach space. The participant also noticed clients engaging more with others and increasing their creativity in their movement vocabulary.

Participant #5: The participant used his experience working with male clients in a group as a basis for his response. Before treatment, the participant noticed clients were more bound in their torso and exhibited poor body awareness and core-distal connectivity, as evidenced in the clients only using their limbs to move. Movements were lacking creativity in that they were more aerobic or “gym-like” movements. Their effort life exhibited an affinity for indirecting, accelerating with passive weight. Clients moved only one dimensional and only within the mid to upper levels. However, in these levels the clients were “very flat. They [were] not stretching all the way to the roof.” The clients did not utilize the floor or entire space of the room and moved only in near reach space with no shaping in relation to those around them.

During and in the middle of treatment, the participant noticed, “More combative movements, not softness” as well as weight in clients’ movements. By discussing and encouraging the clients to use all three levels of space, the clients began to use different levels and open up into more 3D movement. Clients were also encouraged and more open to begin dancing with images, fantasizing, and experimenting with their movement. After treatment, the clients exhibited more 3D movement, free flow, and weight when in contact with other dancers and clients. They were also able to engage in level changes and demonstrated comfort in going to the floor without triggering a traumatic memory.

Participant #6: The participant indicated that she did not see that much change in clients to notate middle or after treatment movement profiles, as she was only with clients for a limited amount of time. The participant emphasized that she is only able to work on finding a
homeostasis or baseline for the clients within their standard treatment time of 5 days: “I try to plant seeds here and there, but again the consistency is not enough for me to get really in there. Plus I don’t want to… I got to keep them safe; I don’t want to send them off when we have got to something, and they don’t have anywhere to go to follow up with it.” The participant was therefore only able to answer what was presented to her before treatment. For the female clients in general, she observed poor core-distal connection and an enclosed posture. The clients also expressed an affinity for passive weight, decelerating, and free flow: “You see them walking in their bodies, but they are not there.” She noticed they were often in Dream state.

For the male clients, the participant observed more binding and an affinity for fighting qualities such as accelerating. Male clients were also often in the Wall shape. The male clients exhibited poor impulse control as evidenced by an inability to sit still. An interesting note is that she noticed a difference in movement qualities in male clients between those that were perpetrators of women and those that were perpetrators of children or the same sex. In the perpetrators of same peer group and the opposite sex, the clients exhibited more wall shape, and an affinity for more fighting qualities, notably accelerating. She also noted poor anger management in these clients. For those clients who were pedophiles or same sex perpetrators, she noticed movement qualities more like the female clients, as evidenced by affinities to retreating, and enclosing postures, often in screw shape. These clients were also more often in Dream state. The participant hypothesized that they are “more connected with their shame.” For both sexes, the participant noticed an ability to engage in good upper-lower connectivity when the clients were in group and were moving to music. The participant assumed that since music and dancing is prevalent within African American culture, i.e. knowledge of social dances such as Stepping or Hip-Hop, African American clients are able to move comfortably and utilize increasing
pressure. However, the participant noticed that after the music stopped, the clients’ bodies almost immediately re-patterned back to poor connectivities.

Themes and observations: This question seemed difficult for participants to answer and to respond succinctly to, which may in part be attributed to some participants not using LMA terminology as frequently as others in their clinical setting or using a different interpretation of LMA terminology than others. In addition, some participants expressed a preference in noticing only certain elements such as Effort. Quite a few also were unclear or unsure of the correct movement quality indicators, as most would say strong weight, and after further questioning, would indicate passive weight.

Although all responses were subjective to the participants’ observations, there were some similarities in movement for both male and female clients before and after treatment. Responses show that there was a prevalence of held torsos, poor breath support, and poor core-distal. They also showed poor upper-lower connectivity, evidenced by an inability or difficulty in grounding themselves, which resulted in poor impulse control and small windows of tolerance. Most female clients indicated an affinity for passive weight, indirecting, binding, and decelerating. Male clients, in comparison, indicated an affinity for passive weight, binding, indirecting and accelerating. Both sexes moved only in near space and exhibited an apprehension for moving throughout the space and moving within all three levels. After treatment, participants noted for both sexes an ability to access free flow, directing, and increasing pressure. They demonstrated an increased comfort in locomotion through space, accessing mid and far reach space, and level changes, and an overall increase in movement creativity.
10. If working with both men and women, what were the differences and/or similarities in their approach to movement and/or dance?

Participant 1- In reference to working with her male clients at a previous location, the participant reported that she was aware of how she may be perceived by the adolescent boys and altered her therapeutic approach to be more direct and movement based then dance oriented. For her female client, with whom she based most of her responses, the participant stated that though movement was difficult for the client due to body insecurity, she was able to access movement in her body and was an approachable and willing participant in DMT sessions.

Participant #2: The participant stated that both clients liked to dance and were engaging and willing participants in movement sessions: “They were good at dance, so it was a positive thing for them.” The younger client was also familiar with DMT, as she had engaged in it with a previous therapist.

Participant #3: The participant responded that when doing movement groups with male clients, clients are resistant, especially in regards to partner work, often saying “I’m not dancing with a man,” or “That’s gay.” Both male and female are apprehensive to movement at first and especially the word dance: “As soon as they hear the word dance, they all shut down. ‘I’m not doing this, I can’t dance.’ But once I show them the movement intervention that shows them that it’s ok, and then they are fine. They are actually more motivated than the females.” The participant also reported that some female clients, once invited to move and engaged in the session, found that they really enjoyed moving, and the DMT sessions became their favorite group. The participant did notice a continued apprehension in male clients during physical fitness activities when asked to bend over to stretch. The participant assumes that this may be in
response to feeling vulnerable in such a movement posture from sexual assault trauma or living in a penitentiary and fearing attack. The participant noticed different responses between the male clients and female clients to her as a female therapist. The male clients would move more willingly and in a more sexual manner with her, whereas the female clients would express a feeling of safety to her in their ability to move.

Participant #4: The participant expressed that she would focus more on pure movement interventions with male veterans rather than creative dance interventions. She noticed male clients were very resistant to moving in general and needed an intent or explanation for moving. In response, the participant engaged clients in more game-like movements rather than creative movement. The participant recalled one movement session in which she did a more Chacian style movement group, and stated that although the clients were moving and participating, she was uncomfortable due to the movements by the men. They became more sexual in nature, and the men made comments such as, “Yeah I like the way you move. Your body looks nice.” As a result, the participant refrained from those types of interventions. In regards to her female clients, the participant expressed that female clients were more receptive to movement as a whole, but again interventions had to be codified as an “activity” rather than dancing to activate participation. Within those movement groups or activities, the participant would work more with small movements like breath work and increasing body awareness through sensory awareness.

Participant #5: The participant expressed that both male and female clients were extremely apprehensive to movement in beginning of treatment. He also stated that female clients would not go to the floor because “it is too dirty.” The participant emphasized that there should be a male therapist working with male clients as well as a female therapist so that clients can be more comfortable and grow more comfortable with movement as a creative expression. He believed
that doing so would help male clients understand and see that dancing does not change or indicate one’s sexual preference.

**Participant #6:** The participant felt that often male clients were more willing to participate in DMT than female clients. The participant commented that male clients believed that DMT sessions gave them an opportunity to be seen, as often times in the hospital unit they weren’t “getting permission to be seen.” On the contrary, female clients were more reluctant to participate in movement groups because they wanted to hide.

**Themes and observations:** Most clients were apprehensive about moving, especially creative movement in the beginning of treatment. The amount of creative movement that was introduced or encouraged by the participant depended on their comfort level with clients. In regards to moving with male clients, the majority of female participants reported an aversion or discomfort in using creative movement or more dance-like movement sessions with male clients due to a prior history of feeling sexually harassed. In contrast, the male participant who worked with male clients reported the importance of male clients to move creatively and a need for a male therapist to show them to do so.

11. **What were some indicators of change with clients and would you describe these changes as an improvement towards recovery?** (Participants responded to this question in regards to changes, either cognitively or physically, that supplemented changes that were addressed in question nine on LMA.)

**Participant #1:** The participant recalled from the case study of the female, adolescent client, an increase in her self-efficacy, assertiveness, and confidence in her life. The participant recounted that the client would give her examples of when she would say “No” and exert control in her life.
Participant #2: The participant reported seeing an improvement in how both clients related to others. For example, in one instance, the participant witnessed the younger client, who had a history of aggressive behavior, sit down and play a board game with another patient with whom she had previously not gotten along. The participant also noted both clients were more assertive and direct in telling the participant what they wanted to work on or do during therapy sessions as well as being receptive to work on issues.

Participant #3: The participant noticed more active involvement by clients in their groups. Clients also took on jobs and responsibilities in their unit, such as becoming Laundry Captain, Maintenance Captain, etc.

Participant #4: In reference to the participant’s work with clients at the sexual trauma center, some of those clients expressed to her that they noticed more body awareness in themselves and an ability to use the techniques she introduced to them, such as breathing and stretching techniques, at home. Clients would also share cognitive and interpersonal improvements, such as using more assertiveness at home, work, and with family members; setting boundaries; improving their anger management; and moving past the trauma. The participant stated, “Sort of their overall sense of wellbeing coming to a point to where they are like, ‘Yes, I have all of these feelings associated with the trauma, but it’s not taking over my life, and I don’t have to feel this way all the time.’”

Participant #5: The participant indicated change in question nine.

Participant #6: The participant reported that due to the clients being treated on a short-term level, a limited amount of individual sessions, and her specific roles within her clinical setting,
there were few drastic indicators of change in her clients. Moments and insights of change were noted on a smaller scale, such as small body awareness of utilizing breath correctly, or a positive mood shift after a movement session. The participant stated that she felt that there have been a lot of powerful sessions in which clients released things or “[let] something go” that was being shown implicitly but not processed or disclosed explicitly. For her male clients, there was a feeling of releasing, and bringing themselves out into space positively or exclamations of “I got something out and I feel better.” For her female clients, due to their higher rate of reluctance and hesitancy to move, establishing for them a feeling of safety and being present in their body indicated a level of change.

Themes and observations: Although there were several different interventions, methods and displays of change noted, a similar theme of assertiveness, control, confidence, and improved interpersonal relations were noted as indicators of change in both male and female clients after engaging in a movement or body-based therapy.
Discussion

This study proved to be challenging and exhibit quite a few limitations in creating ultimate truths for treatment practices and male and female embodiment of sexual trauma. However, I feel that the data, in comparison with previous research, demonstrates a compelling amount of interesting and advantageous results for the treatment of sexual trauma survivors with a body-based therapy as well as eliciting several follow-up questions for future research. The main research questions that I had hoped to answer with this study were what are the challenges and benefits of using a body-based therapy on male and female survivors of sexual trauma, and how and if DMT is a therapeutic intervention that facilitates recovery? Furthermore, I wanted to illuminate whether gender socialization practices have an impact on how trauma is processed and emoted within the male and female bodies. These questions are answered chronologically below.

Some challenges of treating sexual trauma survivors were observed in the themes and observations of questions one and two. In conducting this study, I was surprised at the limited amount of participants I received. It could be hypothesized that there are few sexual trauma survivors to treat, thus few dance/movement therapists that work exclusively with sexual trauma survivors (and thus a finite amount of dance/therapists to interview). However, the impressive magnitude of survivors each year reinforces the statistical lack of sexual trauma survivors entering treatment and therefore, a possible limited number of therapists who have experienced working with this population. Although, the wide variety of clinical settings that emerged with the six participants’ responses to question number two, such as in-patient, out-patient, home care, residential, and short-term, and the admission that they routinely encounter sexual trauma histories in their clients’ biopsychosocial assessments, alludes to the theory that most therapists,
regardless of the type of clinical setting in which they are employed, will encounter a sexual trauma survivor. A search for research on the quantitative amount of sexual trauma survivors in any type of clinical setting did not provide any results; however, it would be interesting to see the results of that study. What this does suggest, then, is that there may be a lack in dance/movement therapists that are willing or comfortable discussing treatment of sexual trauma survivors. Interestingly, several of the participants reported a sense of surprise in being able to discuss treatment of sexual trauma survivors, as most are not given the opportunity to do so.

Another challenge is that even though there may be a presence of sexual trauma survivors in a clinical setting, the amount of which the survivor receives treatment for sexual trauma while in treatment depends on the clinical setting’s methods and mission. According to several participants’ responses to question five, there are certain clinical sites and settings that do not encourage counseling or treating sexual trauma—or at least sexual trauma as it emerges during group therapy. This may be in part due to the amount of time the survivor is admitted for treatment, the acuteness of other presenting problems or mental illnesses, and the ability of the therapist to process sexual trauma by mandates from the site. For example, participant three and six were at a substance abuse center and inpatient psychiatric hospital, respectively, whose main goals were not to treat sexual trauma. If a client brought up sexual trauma during groups, the participants were only able to validate the survivor’s responses, defuse the reaction, and redirect the survivor to his/her primary individual therapist outside of the group therapy session. However, both participants noted that during their body-based treatment sessions, survivors would often have a strong visceral reaction from a triggered sexual trauma memory. The commonness of sexual traumatic memories resurfacing during a body-based trauma therapy session is why Babette Rothschild (2000) recommended that mental health professionals
working with traumatized individuals be cognizant of survivors’ body awareness and the potential of clients going outside their windows of tolerance. This is especially true while leading survivors through sensory and somatic therapeutic work. Thus, all participants had to be conscious and extremely aware of not re-traumatizing clients.

Due to the need for re-programming the brain, sexual trauma therapeutic work can be a long and arduous process. This leads to the question, if body-based therapy helps increase the body awareness and promotes processing of implicit reactions of the body, would it not make sense to also treat sexual trauma as it comes up in groups rather than postpone or procrastinate the recovery process? Or should the clinicians address only the more acute presenting problems such as substance abuse and/or psychosis? Does this redirecting of processing to certain clinicians emphasize silencing the trauma? Furthermore, a common coping mechanism of sexual trauma survivors is substance abuse and risky or self-injurious behavior. This is evidenced in participant six’s response to question number four, in which she states that her client’s have disclosed that they turn to substances to numb the body and mind from traumatic memories. So, a question may be, which do you treat first, the trauma or the substance abuse?

An answer may be found in the amount of outpatient clinics and services available to certain demographics of sexual trauma, and the lengthy process in which sexual trauma needs to be treated. As question number three shows, sexual trauma does not discriminate by race, sex, or socioeconomic status. However, some survivors who have access to outpatient care and services that can devote more time and money to treatment may have a higher rate of recovery. The success of participant five may be in part that he worked with his survivors for six months, three times a week, in comparison to other participants, who met with their clients one half hour to an
hour a week for a few months, and, for some, as few as one week. Therefore, some challenges for treating sexual trauma as a whole is the long time it needs to be treated, and a limited amount of continuation of care services, especially in low income areas. This combination of not being able to process sexual trauma or access a continuation of care service creates a vicious cycle for some survivors, who turn to negative coping mechanisms, such as substance abuse.

Not only is there a disparity among social classes when it comes to treatment, but there is also disparity among victims and perpetrators. Although participants responded, without questioning, to an aversion to treating perpetrators, this is the opposite of how society has promoted the healing of sexual trauma. According to the Illinois Coalition Against Sexual Assault (2012), there is an estimated amount of $26,831,000 general revenue funds going to the treatment, incarceration, and social services for sexual perpetrators, whereas only $4,193,700 general revenue funds goes to survivors. In addition, the small number of perpetrators prosecuted (9%), sexual trauma cases going to trial (5%), and the greater amount of services given to perpetrators, may give an impression of indifference or unimportance to sexual trauma survivors and their plight.

Another challenge in using body-based therapy with survivors of sexual trauma is the level in which the dance/movement therapist attunes to the client’s bodily movements and inner state. As Valentine (2007) suggested, DMT’s unique capabilities of integrating the mind and the body while attuning to the body of the survivor helps make this therapeutic method successful. However, attuning to the body of a sexual trauma survivor without the ability for the therapist to ground themselves or be comfortable in treating this type of population may be triggering or uncomfortable for certain dance/movement therapists. As Herman (1997) presented, those who
bear witness to acts of human atrocity and evil, are caught in the line between victim and perpetrator. Therefore, in order to avoid vicarious trauma or negative transference, there must be a level of expertise and groundedness in the active counselor. Although participants were not questioned on their level of study or research on sexual trauma survivors and its implications, another research question would be what is the level of education and comfort dance/movement therapists have in sexuality and sexual trauma? Furthermore, how does that level of education or insight impede or benefit their therapeutic work?

Although working with a body-based therapeutic method may pose a challenge for some inexperienced clinicians in therapeutic sessions, it may also point to DMT’s efficacy in treating sexual trauma survivors. By focusing on the body and understanding the body’s reactions to trauma, the survivor can begin to find ways to recuperate from triggered bodily memories and move into recovery. As evidenced in participant’s responses to question number eight of what interventions were successful in treating these types of clients, the interventions were based on creating a sense of control, assertiveness, and self-empowerment in the survivor. By understanding and controlling their responses and their body as a whole, survivors could move past debilitating visceral reactions, maladjusted reactions to interpersonal relations, and self-injurious behavior and move forward into productive, healthy lives. A good example of this ability is showcased in participant five’s work, coincidently the only participant who worked with survivors on a long-term basis and solely treated sexual trauma. His treatment method, which has produced group sessions in which male survivors are moving, falling, and supporting each other in creative dance, shows the incredible impact in which body-based therapy can be successful in treating the sexual trauma survivor.
Furthermore as evident in the participants’ responses to question seven, one of the benefits of using DMT with this type of population is that it is generally client-driven and “going with the moment” as one participant stated on pg. 55. In accordance with the auxiliary question of what DMT style the participants used, all participants employed Chacian technique, which adheres to a loosely structured approach in which clients can initiate movement and explorations within safe guidelines supplied by the therapist. In effect, DMT allows the survivor to be the guide and director of their own trauma recovery. The giving of control and letting the survivor be the guide to what is acceptable and what is not is the basis of sexual trauma therapy, as each trauma story is unique and how trauma is expressed in the body is unique. As evidenced in question four, and the tremendous amount of unique case studies throughout the data, trauma affects the individual in a variety of mental, social, and physical ways. For example, some of the common themes that emerged were anger management, substance abuse, self-harm (in the form of cutting or compulsive, often injurious, masturbation), promiscuity, risky sexual behaviors, depression, and PTSD. However, not all survivors had one or more of these problems. Therefore, DMT’s ability to cater to the specific unsaid needs of the survivor points to its efficacy. One example of this was in the successful case reported by participant one of the 18 year old, female client recovering from childhood sexual trauma. Although her biopsychosocial history pointed to a variety presenting problems to treat, the participant focused on what the survivor’s body was expressing—binding, passive weight, little grounding abilities, and indirecting. By attuning to the specific client’s needs, the participant was able to engage the survivor in a dance that allowed her to become a “Warrior” and “Queen.”

Although there may be different interventions used with survivors, the data showed similarities in how sexual trauma was first presented in movement, regardless of gender. These
similarities were poor breath, poor core-distal and upper-lower patterns of connectivity in the Body category; binding, passive weight, and indirecting in the Effort category; and using only near space, with little to no shaping in the Shape category. After treatment, participants noted for both sexes an ability to access their free flow, directing, and increasing pressure qualities. Also evident was increased comfort in moving through space, accessing mid and far reach space, level changes, and movement creativity. The one difference between male and female survivors was that males tended to be accelerating in their movements whereas females tended to be decelerating. The data may point to what was earlier hypothesized in Kaylo’s work describing gender specific movement in which, in reference to Laban, feminine characteristics were the indulging Effort quality, as is decelerating, and the masculine characteristics are in the fighting Effort quality, as is accelerating.

In accordance with the data presented, and to address the question of whether gender socialization practices affects how male and female survivors emote or process sexual trauma, the difference between female and male survivors can be noted in the common coping mechanisms employed by each sex, their perception of dance/movement therapeutic work, the sex of the therapists in attendance, and their interpersonal relationship skills. In relation to male survivors’ coping mechanisms, they often responded externally to their trauma as manifested in aggressive behavior, poor anger management, and becoming perpetrators themselves. Male survivors were also more self-injurious in the form of compulsive and aggressive masturbation. In contrast, female survivors displayed more internally destructive behavior, such as suicidal ideation and self-harm in the form of cutting and promiscuity. These differences are in accordance with previous research studies that show that male sexual trauma survivors, in an effort to prove their masculinity react externally and engage in hyper-masculine, aggressive
and/or self-destructive behavior, whereas female trauma survivors react internally, are often depressive, and display self-harming behaviors such as cutting, or promiscuity (Bruckner & Johnson, 1987; Darves-Bornez, et. al., 1998; Dimock, 1988; McBride, 2011; and Winder, 1996). Although, it is important to note that, although the common coping mechanisms of male sexual trauma survivors is aggression, not all male sexual trauma survivors perpetrate, especially those who receive therapy and support from significant figures in their lives (Male Survivor, 2007). The internal coping mechanisms of female sexual trauma survivors and external coping mechanisms of male sexual trauma survivors elicited a future research question: does the physiology of females and males influence how each gender manifests and processes sexual trauma?

Data responses show that gender socialization practices have also impacted how male and female sexual trauma survivors approach a body-based therapy, such as DMT. This factor may pose another challenge for dance/movement therapists who wish to treat both sexes. In reviewing participant responses to question 10, both sexes were apprehensive about participating in DMT sessions. Once engaged, however, the majority of both sexes found the therapeutic method enjoyable and beneficial. However, an important ability for female therapists who are treating male sexual trauma survivors, or male clients in general, to have is an ability to redirect clients who are overstepping their boundaries or making sexual harassing comments. As female participants one, three, and four reported, it was difficult to conduct a Chacian or creative dance motivated therapeutic session without male clients making suggestive or objectifying comments to them, and as a result, most do not utilize a Chacian or creative movement technique with male clients. This evidence points to the importance of male dance/movement therapists leading or assisting female dance/movement therapists in therapeutic groups with male clients—not only as
a way to help contain the group and establish boundaries, but also, as participant five, who is a male therapist reported, to show that it is okay to move, and it does not affect clients’ sexual orientation or masculinity. Male sexual trauma survivors often fear that their masculinity or sexual preference has been compromised as a result of sexual trauma, so convincing this population that DMT—which many attribute to be feminine or too expressive (Capello, 2011)—is effective may be more challenging than with female sexual trauma survivors. However, just as sexual trauma has been misconceived to be a female-only problem, in that DMT is a female-only therapeutic method, the research provided demonstrates that both sexes are affected by sexual trauma and can benefit from DMT.

In addition to the limited number of participants available to contribute to this study, other limitations include the amount of interventions, subjectivity of the clients’ responses to interventions by participants, and muddled LMA terminology. In compiling the data, there was some difficulty in participants’ providing detailed responses to clients’ movement profiles using LMA terminology. This difficulty could be attributed to the unfamiliarity of Laban terminology due to infrequent usage. Or, it could be the improper memory recall of clients’ movements. The difficulty could be also be attributed to different interpretations of Laban terms as they apply to movements, as evidenced by an uncertainty expressed by participants of noting either passive or strong weight. The brevity could have even been due to preferences in noticing only certain elements of LMA. As participants expressed, they noticed only certain elements such as Effort, and thus, were more succinct in their responses for that category.

Another limitation was the limited number of interventions described and the subjectivity of the clients’ response by participants. This limitation may not provide enough evidence of what empirically works with sexual trauma survivors. Overall there is a lack of empirical research on
sexual trauma survivors, and this lack of empirical research may contribute to the general public and conventional psychotherapeutic community’s apprehension in acknowledging DMT’s viability as a legitimate therapeutic method. However, with continued research, such as this study, or by generating more single case designs or quantitative research, this assumption could be addressed.

Even though there is more coverage of sexual trauma in the media, there is still a need to halt misconceptions of sexual trauma, discourage rape culture and gender stereotypes, and encourage sexual trauma advocacy, research, and treatment. Even in the realm of therapy, there seems to be an unintentional stigma against sexual trauma survivors, as participants did not set out to exclusively work with sexual trauma survivors but engaged in treating this population through happenstance. Survivors of sexual trauma are rarely therapists’ first choice of clientele; does this push survivors further toward the margins of society and deeper into silence?

On a personal note, this research process felt parallel to the challenges sexual trauma survivors face in treatment and in voicing their struggles. That is, at times, this study was challenging, often stifling, and eventually releasing. It has given me a nudge forward in my struggle of finding my own voice. I hope, one day, that small voice will, for me and others, become a roar.

And I felt I was being heard for the first time
It would not be singing, as we know it
It would be a roar.
Oh I think it would be a roar
Oh it would come
Oh it would come, from the bottom of my feet!

It would be

I really think that

It would be like a lion

Just roaring

It wouldn’t be singing, as we know it

It wouldn’t be words

It would just be

Like-the-earth’s-first-utterance.

I really do feel so.

(Smith, 2003, p.100-101)
References


http://www.rainn.org/statistics


Appendix A

Columbia

Informed Consent Form

Consent Form for Participation in a Research Study

Title of Research Project: Dance/movement Therapy in the Treatment of Male and Female Sexual Trauma Survivors

Principal Investigator: Sarah Winkler

Faculty Advisor: Andrea K. Brown, ADTR, NCC, LCPC

Chair of Thesis Committee: Susan Imus, MA, ADTR, LCPC, GLCMA

INTRODUCTION

You have been invited to participate in a research study to document and analyze the reactions of male and female sexual trauma survivors to dance/movement therapy treatment. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called ‘informed consent.’ You will receive a copy of this form for your records.

You are being asked to participate because you are a licensed dance/movement therapist who is currently working, or has worked in the past, with male and/or female survivors of sexual trauma.

PURPOSE OF THE STUDY

The purpose of this research study is to research, document, and analyze how dance/movement therapy can benefit survivors of sexual trauma.
PROCEDURES

- Participants will be asked to participate in research study via social networking such as the American Dance Therapy Association web boards or forums and referrals. Those participants whom are interested in participating will be included if they are currently working, or have worked in the past, with male and/or female survivors of sexual trauma.
- Depending on participant preference, participants will receive a phone call, conduct a face-to-face interview or receive an email or mailed document from the principal investigator with an 11 question interview. The interview will ask for generic information about each client and treatment interventions used. Questions on how clients responded to these interventions will also be asked.
- Interviews should take between 45 minutes to an hour to complete. A follow-up interview may be arranged with participant to ensure clarification of responses.

If you agree to participate in this study, you will be asked to do the following:

- Provide contact information of either phone number or email address to primary investigator.
- Provide availability for a scheduled phone call to conduct interview or complete and return emailed questionnaire within two weeks of reception.
- Provide schedule availability to primary investigator for a potential follow-up interview.

POSSIBLE RISKS OR DISCOMFORTS

- I believe there are no known risks associated with this research study; however, a possible inconvenience may be the time it takes to complete the study.

POSSIBLE BENEFITS

You may not directly benefit from this research; however, I hope that your participation in the study may increase research material available of dance/movement therapy treatment for survivors of sexual trauma.

CONFIDENTIALITY

- Pseudonyms will be created to protect therapist and client confidentiality. Any and all identifying information will be omitted and only generic terminology will be used. Data collected via email submission will be received solely on a specially designated password protected and fire-walled email account. Audio taped interviews will be given and transcribed by only the primary investigator. Written and audio records will be kept no longer than two years after reception and will only be accessible to the primary investigator.
The following procedures will be used to protect the confidentiality of your information:

1. The investigator will keep all study records locked in a secure location.
2. Any audio tapes will be destroyed after two years.
3. All electronic files containing personal information will be password protected.
4. Information about you that will be shared with others will be unnamed to help protect your identity.
5. No one else besides the investigator will have access to the original data.
6. At the end of this study, the investigator may publish their findings. You will not be identified in any publications or presentations.

RIGHTS

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty. Take as long as you like before you make a decision. I will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Sarah Winkler at 630-643-6943 or the faculty advisor Andrea K. Brown at 312-369-8548. If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at 312-369-7384.

COST OR COMMITMENT

- Please expect to give up to one hour of your time for this research study.

PARTICIPANT STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form.

_______________________  ___________________________  ________
Participant Signature:    Print Name:                   Date:
_______________________  ___________________________  ________
Principal Investigator’s  Print Name:                   Date
Signature
Appendix B

Columbia COLLEGE CHICAGO

QUESTIONNAIRE

Please answer these questions to the best of your ability:

1. Describe your clinical setting and how many years you have been working with adult clients recovering from sexual trauma.

2. What are the demographics, in general terms, of your clients? (gender identity, race, age)

3. What, if any, was the initial presenting problem for the clients (depression, bipolar, etc.) and which type of sexual trauma did the client experience (i.e. rape, childhood abuse, date rape, war rape) ?
4. If working with men and women clients, what, if any, are the differences in presenting problems between men and women? Please give an example.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

5. When during treatment were you able to focus solely on the sexual trauma? Or if not, why were you unable to focus solely on the sexual trauma?

____________________________________________________________________________________

____________________________________________________________________________________

6. What, if any, types of DMT interventions do you not practice with these types of clients?

____________________________________________________________________________________

____________________________________________________________________________________

7. What was your most successful DMT intervention with these types of clients?

____________________________________________________________________________________

____________________________________________________________________________________

8. What movement qualities (using LMA language if possible) became most salient before, during and after your time working with the clients?

____________________________________________________________________________________

____________________________________________________________________________________
9. If working with both men and women, what were the differences and/or similarities in their approach to movement and/or dance?

__________________________________________________________________________

__________________________________________________________________________

10. What were some indicators of change with clients and would you describe these changes as an improvement towards recovery?

__________________________________________________________________________

__________________________________________________________________________

11. Why and how do you think dance/movement therapy is effective in treating sexual trauma compared to more traditional forms of psychotherapy?

__________________________________________________________________________

__________________________________________________________________________

Thank you for your participation! Please do not hesitate to contact me if you have any questions!

Sarah A. Winkler
dmtstudy.winkler@gmail.com
Appendix C

Call For Participants: Dance/Movement Therapy in the Treatment of Male and Female Sexual Trauma Survivors

I am a dance/movement therapy graduate student at Columbia College Chicago and I am currently looking for participants for my master’s thesis. My study will research, document and analyze how dance/movement therapy can benefit survivors of sexual trauma.

I am seeking participants for this study who meet the following requirements:

- A licensed dance/movement therapist who is currently, or has treated, male and/or female sexual trauma survivors.
- Between the ages of 23 and 65 years of age and English speaking.
- Willing to participate in a taped phone or face-to-face interview in which they will recount their treatment philosophies and experiences with this population. Participants may have the option of receiving an emailed or mailed questionnaire if an interview is not possible.

Participants will have the option of receiving an emailed questionnaire however a phone interview will be encouraged, to ensure clarity and cohesive documentation of responses. The interview will address participants’ experiences and any challenges in treating male and/or female sexual trauma. The interview process will take approximately 45 minutes of the participant’s time. Participants may be asked to participate in a follow-up interview to ensure clarity of responses. The follow-up interview will not exceed more than thirty minutes.

If you meet participation criteria and are willing and interested in study participation, please contact me via email (dmtstudy.winkler@gmail.com) within the next two weeks. If you meet participation criteria, you will be mailed a postmarked informed consent form for you to sign. Once this form is received, preferably within two weeks of reception, I will contact you to conduct the interview.

Thank you for your time and consideration.

Sarah Winkler, Dance/Movement Therapy MA Candidate, Columbia College Chicago
dmtstudy.winkler@gmail.com
## MACS Coding Sheet

### Appendix D

by Sarah Winkler

<table>
<thead>
<tr>
<th>Date:</th>
<th>Observation Subject:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Session No.:</td>
</tr>
</tbody>
</table>

### BODY

<table>
<thead>
<tr>
<th>Needs Improvement</th>
<th>Good</th>
<th>Excellent</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breath (breath control, vertical throughness)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core-Distal Connectivity (Total Body opening and closing, hang and hollow)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head-Tail Connectivity (yield, push, reach, pull, heel rock)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper-Lower Connectivity (femoral flexion, sagittal pelvic shift, sagittal propulsion, lateral pelvic shift)</td>
<td></td>
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<tr>
<td>Body-Half Connectivity (homolateral pattern)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-Lateral Connectivity (creeping, arm circles, knee drops leg swings)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Active/Held Body Parts

<table>
<thead>
<tr>
<th>Hands</th>
<th>Arms</th>
<th>Head</th>
<th>Upper Torso</th>
<th>Lower Torso</th>
<th>Legs</th>
<th>Feet</th>
</tr>
</thead>
</table>

Body Part Phrasing:
- Simultaneous
- Successive
- Sequential

Effort Phrasing Types:
- Even
- Inc. Intens.
- Decr. Intens
- Incr-Dcr
- Dcr-Incr.
- Accented
- Vibratory
- Resilient

### EFFORT

<table>
<thead>
<tr>
<th>Flow</th>
<th>Freeing</th>
<th>Binding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Decreasing Pressure</td>
<td>Increasing Pressure</td>
</tr>
<tr>
<td>Time</td>
<td>Decelerating Time</td>
<td>Accelerating Time</td>
</tr>
<tr>
<td>Space</td>
<td>Indirecting</td>
<td>Directing</td>
</tr>
</tbody>
</table>

States:

<table>
<thead>
<tr>
<th>Rhythm</th>
<th>Weight, Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
<td>Space, Flow</td>
</tr>
<tr>
<td>Mobile</td>
<td>Time, Flow</td>
</tr>
<tr>
<td>Stable</td>
<td>Weight, Space</td>
</tr>
<tr>
<td>Awake</td>
<td>Space, Time</td>
</tr>
<tr>
<td>Dream</td>
<td>Weight, Flow</td>
</tr>
</tbody>
</table>

Drives:

<table>
<thead>
<tr>
<th>Action</th>
<th>Weight, Space, Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Flow, Space, Time</td>
</tr>
<tr>
<td>Spell</td>
<td>Flow, Weight, Space</td>
</tr>
<tr>
<td>Passion</td>
<td>Flow, Time, Weight</td>
</tr>
<tr>
<td>SHAPE</td>
<td>Pin</td>
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<tr>
<td>---------------</td>
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</tr>
<tr>
<td>Spoking</td>
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<tr>
<td>Arcing</td>
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<td>Carving</td>
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<td>Advancing/Retreating</td>
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<tr>
<td>Rising/Sinking</td>
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<tr>
<td>Enclosing/Spreading</td>
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<table>
<thead>
<tr>
<th>SPACE</th>
<th>Vertical</th>
<th>Plane</th>
<th>Dimension</th>
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<tbody>
<tr>
<td></td>
<td>Horizontal</td>
<td>Plane</td>
<td>Dimension</td>
</tr>
<tr>
<td></td>
<td>Sagital</td>
<td>Plane</td>
<td>Dimension</td>
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| NOTES          |           |       |           |
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