MAPS TO SUCCESS; THE DANCE MOVEMENT THERAPIST AS INNOVATOR AND ASSIMILATOR—preparation for WORKSHOP 2

(July 11 and July 25 Australia: July 10 and July 24 USA)

Hello Everybody and Welcome!

For those of you continuing to Workshop 2 from Workshop 1, our time together has been inspiring and enlightening and I look forward to our next two sessions, as we explore Workshop 2: **THE ROLE OF DANCE THERAPY IN HEALING FROM LIFE'S TRAUMAS.**

For those of you just joining us for the next Workshop: **THE ROLE OF DANCE THERAPY IN HEAING FROM LIFE'S TRAUMAS,** we look forward to meeting you and having you join us on this exciting journey. And for those of you joining us now for Workshop 2, please peruse the attached letter, and the first few handouts, as general preparation for the Workshop, which participants in Workshop 1 have already downloaded.

Now, for EVERYONE: if I haven't already confused you about the attachments---------I am sending you a few articles as background reading on Trauma; in general, to prepare you for our next two sessions. Essentially, though, our sessions will focus upon how the Dance Therapist creates a safe and transformative environment for clients/patients, in order to assist them in developing, releasing, recuperating, etc. from various degrees and levels of traumatic events (to be discussed and defined).

We will be exploring a variety of DMT interventions, based upon focused dance movement observations of this facilitator, whilst working with trauma survivors worldwide. We will be exploring ways to uncover, discern and work with the embodied traumatic incident(s). Outcomes discussed will be focused upon assisting clients to move through (and out of) the *EMBODIED (I.E. Body Held)* traumas, and into a more relaxed, productive, and self-evolved emotional, physical and spiritual life.

Please feel free to contact me directly for any comments, reactions to sessions, questions, etc. Contact information in on attached letter. Looking forward to seeing you soon.

Warmest Regards to All,

MAPS TO SUCCESS

The Dance Movement Therapist as Innovator and Assimilator

Presented by : Dr. Marcia B. Leventhal, PhD, CMA, BC-DMT

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ON ZOOM

(**Australian dates** are June 13 and June 27 –Workshop One;

July 11 and July 25-Workshop two; both at 10 am -12:30 pm)

(**U.S. Dates** are: June 12 and June 26-Workshop one; July 10 and July 24, Workshop Two; check for times in your region)

Hello and Welcome All,

I so look forward to meeting with you soon and exploring, discovering, and connecting through these exciting Dance Movement Therapy processes . In order to prepare for these sessions I am attaching a variety of material for your perusal: some are to stimulate some background thinking and information, and some are for your personal use to keep track of your own discoveries and processes during the actual sessions.

Here also are a few suggestions to help you prepare for our tine together:

1. Where possible, please prepare your space for these sessions so that you be able to explore without interruption and with as much movement area as possible (obviously there are limitations for us all, but just a little prep will allow you to participate fully, without worry). Dress comfortably so that you may move without clothing restrictions, and of course have water and snacks available, if and when needed.

2. Have available writing and drawing materials-----nothing fancy; just markers or crayons, pen or/pencils, blank paper (a variety of sizes where possible, but not crucial).

3. Please pace yourself during our time together, and move at a level that you feel comfortable, and are able to hold the space safely for your own processes. Out time together is educational and not a time of group therapy. Dance Movement exploration can often lead us to deep, insightful places, and this Facilitator will be guiding you through a variety of exploration processes, through lecture, PPT, dance movement and discussion. Our goal is to deepen and refresh and even renew our connection to therapeutic dance and our own personal place in our professional development.

4. ***Please make multiple copies of the first three charts in the handouts, as these will be valuable tools for your use to keep track of your own discoveries and processes.***

Feel free to contact me prior to our sessions for any questions or concerns.

Warmest Regards to All,

Marcia

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Brief Biography

Dr. Leventhal holds a Doctorate in Clinical Psychology, is a Board Certified Dance Movement Therapist (BC-DMT), is a Certified Movement Analyst (CMA) and she is the 2019 recipient of the ADTA Lifetime Achievement Award.

Teaching and lecturing worldwide, she has received many awards and grants for her innovative and healing training programs. She is a widely published author and is the process of completing her book, **Journey to the Heart of Matter; Dance Therapy as an Agent of Change and Transformation.** ©

Dr. Leventhal's theoretical contributions to the field of Dance Movement Therapy have allowed one to develop age and developmentally appropriate treatment programs for a wide variety of both clinical and non-clinical populations, supporting dance therapy within a holistic/humanistic treatment model.

Dr. Leventhal was the 2007 Marian Chace honoree and key- note speaker for the American Dance Therapy Association. She was the Director and Developer of the Graduate Dance/Movement Therapy Program at New York University, where she was a Professor from 1973-1990. She also founded the first two European Programs in DMT in Stockholm, Sweden, and in the UK (Froebel College at Roehampton University). Dr. Leventhal has co-founded the International Dance Therapy Institute of Australia, (IDTIA) where she directed education and training for the IDTIA for 16 years. She co-founded the Dance Therapy Institute of Princeton, the first post-educational training institute for DMT offering advanced training and founded Dance Therapy Intensive Training Programs in Kyoto, Japan, Buenos Aires, Argentina, Athens, Greece, Istanbul turkey and throughout China. Dr. Leventhal is the Co-Founder and Co-Director of the **International Institute for Advanced Training in Dance Movement Therapy**, which is currently directing training programs throughout China, in Istanbul, Turkey, and throughout the USA. Her Master's Thesis, "A Dance Movement Experience with Psychotic Children", (UCLA, 1965), is the first such research thesis in the field of DMT.

Within the ADTA she is a previous Co-Editor in Chief of the Journal, a former Board Member, and has served on and helped to develop numerous ADTA committees since their inception.

Some of Dr. Leventhal's holistic healing model of DMT is informed by her training worldwide in alternative and complementary healing practices, and her experiences as a professional actor and former professional dancer. Her dance therapy practice has included work with exceptional children, adolescents, adults, juvenile offenders and incarcerated men, and utilizes dance therapy as a primary therapeutic modality in her private practice.

Dr. Leventhal acknowledges with gratitude her early mentors for their guidance and support: Dr. Alma Hawkins, Dr. Valerie Hunt, Dr. J. Alfred Cannon, and Mary Whitehouse. Other teachers of inspiration who have assisted in her unfolding include but are not limited to: Irmgard Bartenieff, Margie Beals, David Bohm, Merce Cunningham, Blanche Evan, Anna Halprin, Michael Harner, Jean Houston, Judith Kestenberg, Joseph Chilton Pearce, and Swami Rama.

The Art of Embodiment; Whole Person Psychology
Marcia B. Leventhal, PhD, CMA, BC-DMT, NCC

MY EMBODIED PSYCHODYNAMIC JOURNEY TOWARDS ESSENCE, WHOLING/HEALING

RELEASING:

RECOVERING:

RECLAIMING:

RELEIVING:

RESTORING:

TRANSFORMING- From Body Awareness to Expressive Gesture, to Meaning and Manifestation

WHO I AM?	HOW I AM?	WHERE I AM?	WHAT I AM?

SELF OBSERVATION INDEX

NAME: _____ SESSION: _____

A. PERSONAL THEME:
1. Psychodynamic

2. Movement

B. WHICH THERAPEUTIC PROCESS WAS FOREGROUND FOR YOU TODAY?

C. WHAT WERE YOUR PREDOMINATING MOVEMENT QUALITIES OR EFFORTS?

D. WHICH BODY PARTS WERE KEY MOVERS TODAY?

E. FOREGROUND AWARENESS STIMULATED BY MOVEMENT

	(Less)					(More)	State Briefly:
1. THOUGHTS	0	1	2	3	4	5	
2. FEELINGS	0	1	2	3	4	5	
3. IMAGES	0	1	2	3	4	5	
4. MEMORIES	0	1	2	3	4	5	
5. INSIGHTS	0	1	2	3	4	5	
6. SENSATIONS	0	1	2	3	4	5	
7. OTHER	0	1	2	3	4	5	

F. GENERAL AFFECTIVE STATE

Exhilarated	0	1	2	3	4	5
Very Comfortable	0	1	2	3	4	5
Moderately Comfortable	0	1	2	3	4	5
Anxious	0	1	2	3	4	5
Tired	0	1	2	3	4	5
Confused	0	1	2	3	4	5
Angry	0	1	2	3	4	5
Sad	0	1	2	3	4	5
Other	0	1	2	3	4	5

When In Session:

Beginning	Middle	End

SYMBOL:

* LEVENTHAL WORKSHOPS 2021

MOVEMENT PROCESSING INDEX: CONTEXT OF INTERPRETATION

THE ART OF AN EMBODIMENT – MOVEMENT AND EXPRESSION

Session_____ Date_____

I. Experiential (Level of Intervention and/or Current Issue Presented)

II. E/S Trends and Range

III. Theme

IV. Form, Symbols, Elements Emerging (ie. Posture, Use of Parts, Non-Verbal Cues)

V. Theory and/or Psychodynamic Issues Perceived

VI. Mood and/or Emotional Affect Perceived

VII. Summary, Conclusions, Plan

BASIC, BUT KEY, IMPORTANT POINTS

1. Research of Dr. Valerie Hunt (1964), showed that there is a positive correlation between movement range flexibility and flexibility in range of choice/thinking, and an increase ability to think and to abstract

   *(if range of feeling expression, or perceptual reception is limited, then perception leading to reality testing and subsequent interpersonal relating will also be severely impeded)

2. Movement expression as seen in communicative, functionally movement—i.e. pedestrian movement, and personal gestures, are reflective of intra-psychic dynamics.

3. A fundamental belief is that a change in movement expression can result in a personality or behavior change.

4. How the ego is formed according to S. Freud:

   "The ego is first and foremost a body-ego, it is not merely a surface entity, but it is itself the projection of a surface....." The ego is ultimately derived from bodily sensations, chiefly those springing from the surface of the body. It may thus be regarded as a mental projection of the body" (1923, p.96)

5. Organic unfolding as we learn to experience it in our modules will allow us to explore our own tolerance for change and range expansion.

The key elements we are exploring in order to bring life and understanding to the articles that have been assigned, and to the idea of relationship to range of perception are ◦Energy Flow ◦Tension Flow (see Kestenberg and Qualities of Flow on P. 14 of Basic Article) ◦Body Image ◦Theory and Development ◦Felt Level/Thought ◦Metaphors ◦Symbols and ◦Personal Expressive Style

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EIGHT THEORETICAL PRINCIPLES OF DANCE MOVEMENT THERAPY; PARTICULARLY AS THEY RELATE TO THE QUANTUM HEALING DANCE™

Marcia B. Leventhal, Ph.D, BC-DMT, CMA, NCC; 1998, 2009, 2011, 2012

1. The body, the mind and the spiritual aspects of our personalities are in constant and continual connection and interaction. This three-dimensional state of our deepest essence is foundational and core to all healing and change; insight gleaned in one modality will impact or affect experience, perception, and/or movement expression in each other modality.

2. Our expressive and functional movement do express aspects of our personality, our collective unconscious and our own personal developmental history; thus by letting the body work through and find themes,--traumas, pattern, and blocks can be accessed and healed (Freud, Reich, Kestenberg)

3. The non-verbal realms of communicating hold keys to understanding the impact and power of relationships without and before words; and this is basic to the therapeutic relationship
   - Energy leads to emotion leads to motion
   - Dyadic union
   - Mutuality
   - Body ego and impact upon early development

   Elements of non-verbal energy help form, create, and develop the Dance Therapy therapeutic relationship.

4. Expressive movement can be open to interpretation as a message from the unconscious (just like "slips of the tongue," and free association.) It's only by making what's unconscious conscious can changes occur (unconscious is defined as , "those contents of mind that are not present in the conscious field and can include ideas or thoughts, feelings and/or images which have been repressed or suppressed.")

5. In re-learning how to move expressively we are able to expand as well as become aware of maladaptive patterns.

6. Re-learning to move expressively helps us re-establish contact with our inner most being or essence causing an integration of our personality at the deepest level.

7. In moving expressively we learn that there are many levels of accessing information and expressing perceptions simultaneously.

8. Range of motion is correlated to range in options, choices and largesse of life vision.

FORMING THE EMBODIED LANGUAGE OF/IN DANCE MOVEMENT THERAPY

Selected key, psychophysical elements contributing to the forming of a dance/movement therapy model: Our Discrete Language of Movement

Dr. Marcia B. Leventhal, PhD, CMA, BC-DMT, NCC

-breath
-paradigm
-spontaneity
-healing
-flow
-body-image/self concept
-quantum vs. newtonian
-energy
-tension/release
-felt level
-expression
-theme
-release
-body/mind
-forming
-focusing
-the art of embodiment
-dynasphere vs. kinesphere
-psycho-physical
-time
-cellular level
-metaphor
-awareness
-space
-field
-inner vs. outer

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1 Overview

History of Trauma Theory

The relationship between trauma and mental illness was first investigated by the neurologist Jean Martin Charcot, a French physician who was working with traumatized women in the Salpetriere hospital. During the late 19th century, a major focus of Charcot's study was hysteria, a disorder commonly diagnosed in women. Hysterical symptoms were characterized by sudden paralysis, amnesia, sensory loss, and convulsions. Women comprised the vast majority of patients with hysteria, and at the time, such symptoms were thought to originate in the uterus. Until Charcot, the common treatment for hysteria was hysterectomy. Charcot was the first to understand that the origin of hysterical symptoms was not physiological but rather psychological in nature, although he was not interested in the inner lives of his female patients. He noted that traumatic events could induce a hypnotic state in his patients and was the first to "describe both the problems of suggestibility in these patients, and the fact that hysterical attacks are dissociative problems—the results of having endured unbearable experiences" (van der Kolk, Weisaeth, & van der Hart, 1996, p. 50). In Salpetriere, young women who suffered violence, rape, and sexual abuse found safety and shelter, and Charcot presented his theory to large audiences through live demonstrations in which patients were hypnotized and then helped to remember their trauma, a process that culminated in the abrogation of their symptoms (Herman, 1992).

Pierre Janet, a student of Charcot, continued to study dissociative phenomena and traumatic memories. Janet investigated the influence of patients' traumatic experiences on personality development and behavior. He recognized that patients' intense affects were reactive to their perceptions of the traumatic events that happened to them, and he found that through hypnosis and abreaction, or reexposure to the traumatic memories, patients' symptoms could be alleviated (van der Kolk, Weisaeth, et al., 1996). In his early studies of hysteria (1893–1895), Freud, too, was initially influenced by Charcot and

adopted some of his ideas. In *Studies on Hysteria* (1893), coauthored with Josef Breuer, Freud suggested that

> we must point out that we consider it essential for the explanation of hysterical phenomena to assume the presence of a dissociation, a splitting of the content of consciousness. [T]he regular and essential content of a hysterical attack is the recurrence of a physical state which the patient has experience earlier. (cited in van der Kolk, Weisaeth, et al., 1996, p. 30)

Freud and Breuer termed traumatic dissociation "hypnoid hysteria" and highlighted its relationship to a traumatic antecedent. In 1896, Freud suggested that "a precocious experience of sexual relations . . . resulting from sexual abuse committed by another person . . . is the *specific cause* [italics added] of hysteria . . . not merely an agent provocateur" (1896/1962, p. 195, cited in van der Kolk, Weisaeth, et al., 1996, p. 54). In the 1880s, Freud and Breuer as well as Janet independently concluded that hysteria was caused by psychological trauma. They agreed that unbearable reactions to traumatic experiences produced an altered state of consciousness that Janet called "dissociation." According to Janet, dissociation manifested in hysterical symptoms (Herman, 1992). Putting the emotions into words and reconstructing the past helped alleviate the patients' symptoms.

However, Freud eventually moved from what has been termed "seduction theory" to conflict theory (see Chapter 3 for a more detailed discussion of this development), suggesting that it was not memories of external trauma that caused hysterical symptoms but rather the unacceptable nature of sexual and aggressive wishes. What his followers neglected to notice, however, was that whereas Freud privileged intrapsychic theory and fantasy over external trauma, he did suggest that it was possible for external trauma to influence the patient's state of mind (Diamond, 2004). Ferenczi (1933/1955) was the only one among Freud's followers who regarded his patients' stories of childhood sexual abuse as veridical recollections, but he remained somewhat of an outsider in the psychoanalytic movement during his lifetime, his theories gaining favor only in the decades following his untimely death in 1933.

Crisis intervention methods to address traumatic events developed gradually, with the establishment of the first suicide hotline in 1902 in San Francisco. Psychological "first aid" was then further developed in the context of military combat. During World War I, psychiatrists observed that soldiers returned with "shell shock" syndrome. Psychological first aid was first developed to help World War I soldiers overcome their symptoms of uncontrollable weeping and screaming, memory loss, physical paralysis, and lack of responsiveness (Herman, 1992). The goal of psychological first aid was to provide a short intervention that would help the soldiers recover and return to the front as soon as possible. It was observed that by providing intervention close to the front and soon after deployment, traumatized soldiers were able to overcome

their shell shock symptoms and return to active combat duty. In 1923, following World War I, Abram Kardiner started to treat traumatized U.S. war veterans (Kardiner, 1941). Like Janet and Freud, he observed the nature of reenactment, a central construct in modern trauma theory, and noted that "the subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion" (p. 82; also cited in van der Kolk, Weisaeth, et al., 1996, p. 58). Kardiner also foresaw an important controversy that continues to haunt trauma therapists, that is, whether to bring the traumatic memories into the patient's consciousness or to focus on stabilization (van der Kolk, van der Hart, & Marmar, 1996). Although earlier trauma theorists blamed the soldiers' symptoms on their poor moral character, Kardiner understood that any man could be affected by the atrocities of war and that the traumatic symptoms were a normal response to an unbearable situation.

Kardiner and his colleague Herbert Spiegel argued that the most powerful intervention against overwhelming terror was "the degree of relatedness between the soldier, his immediate fighting unit, and their leader" (Herman, 1992, p. 25). Consequently, treatment for traumatized soldiers during the Second World War focused on minimizing separation between these soldiers and their comrades and providing brief intervention methods such as hypnosis. Kardiner and Spiegel warned, however, that cathartic experiences and hypnosis by themselves, without consistent follow-up, were not sufficiently helpful and that unless the traumatic memories were integrated in consciousness the improvement would not last (Kardiner & Spiegel, 1947, cited in Herman, 1992). During World War II, psychiatrists reintroduced hypnosis as a treatment for trauma, and the U.S. Army instituted the use of "group stress debriefing" (Shalev & Ursano, 1990, cited in van der Kolk, Weisaeth, et al., 1996, p. 59).

After World War II, studies on the impact of prolonged stress and trauma on concentration cam survivors coincided with observations of combat stress. Henry Krystal (1968, 1978, 1988) was a psychoanalyst who studied outcomes of prolonged traumatization on concentration camp survivors, observing that "traumatized patients come to experience emotional reactions merely as somatic states, without being able to interpret the meaning of what they are feeling" (van der Kolk, Weisaeth, et al., 1996, p. 60). Krystal elaborated on the diagnosis of alexithymia, a typical syndrome in chronically traumatized people. He described the effect of trauma on the capacity to experience, identify, and verbalize feelings as well as physiological needs and these patients' tendency to somatize affective experiences, express themselves in an overly concrete manner, and their lack of capacity to symbolize and dream. McDougall, who also worked with traumatized patients, suggested that it was not the absence of affect that was the issue. Instead, she stated, her patients "were not suffering from an inability to experience or express emotions, but from an inability to contain and reflect over an excess of affective experiences" (McDougall, 1989, p. 94).

Contemporary trauma theory in civilian contexts developed following the 1942 Cocoanut Grove fire in Boston. During that fire, 493 people perished in a nightclub, many of them trampled to death. Following the tragedy, Dr. Lindemann, who treated a number of the survivors, observed that they displayed common responses. He began to theorize about normal grief reactions, including preoccupation with lost loved ones, identification with the deceased, expressions of guilt and hostility, disorganization, and somatic complaints (Lindemann, 1944). Caplan, who also worked with the survivors of the Cocoanut Grove fire, was the first to systematically describe the components of crisis. He spoke of people's being

> in a state of crisis when they face an obstacle to important life goals, . . . an obstacle that is, for a time, insurmountable by the use of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made. (Caplan, 1961, p. 18)

During the same time Parad was interested in examining the impact of particular types of crises and identified five components that affected victims' abilities to cope with overwhelming life events:

- The stressful event poses a problem which is by definition insoluble in the immediate future.
- The problem overtaxes the psychological resources of the family, since it is beyond their traditional problem solving methods.
- The situation is perceived as a threat or danger to the life goals of the family members.
- The crisis period is characterized by tension which mounts to a peak, then falls.
- Perhaps of the greatest importance, the crisis situation awakens unresolved key problems from both the near and distant past. (Parad & Caplan, 1960, pp. 11–12)

During the Vietnam War, soldiers and veterans returned with incapacitating symptoms that often developed into chronic problems affecting their capacity to cope with, and function in, civilian life. Many of them started to abuse drugs and alcohol, behaved violently toward their partners, or became homeless and unemployable. Lifton and Shatan, who worked with Vietnam veterans, conducted "rap groups" for the veterans, during which they could share their experiences with their comrades and receive validation and support. Based on their work, Lifton and Shatan identified 27 common symptoms of "traumatic neurosis" (Lifton, 1973). These symptoms were catalogued based on the authors' observations of veterans as well as on their readings of Kardiner and the literature on Holocaust survivors and victims of accidents, which they compared with clinical records of Vietnam veterans. Many of

these symptoms were later included in the *Diagnostic and Statistical Manual of Mental Disorders* (third edition; *DSM-III*) diagnosis of posttraumatic stress disorder (PTSD) and utilized in panel discussions leading to the inclusion of this diagnosis (van der Kolk, Weisaeth, et al., 1996). Figley (1978) also contributed to the growing treatment literature on Vietnam veterans, and Shay (1994) made theoretical contributions to the understanding of the long-term impact of combat trauma on Vietnam veterans by applying Greek mythological imagery. He used, for example, the story of Achilles to anchor his discussion of Vietnam veterans' experiences and psychological wounds.

Along with combat trauma and the trauma of Holocaust survivors, trauma in the lives of women moved from the private domain of the home to the public arena as a consequence of the women's movement in the 1970s. Women's consciousness-raising groups shared common characteristics with the Vietnam veterans' rap groups in that they were based on open sharing, validation, and support and "helped overcome barriers of denial, secrecy and shame" (Herman, 1992, p. 29). The purpose was not only to provide psychological healing but to bring about social change in policies and institutions. An epidemiological survey by Diana Russell in the 1980s of more than 900 women chosen at random showed that 1 woman in 4 had been raped and 1 woman in 3 had been sexually abused in childhood, statistics that were quite shocking insofar as such problems had been well hidden and denied until that era (Russell, 1984). The first rape crisis center opened in 1971, and a more comprehensive understanding and treatment of domestic violence followed (Herman, 1992). Additional contributions to the understanding of types of trauma and their impact were made by Lenore Terr (1979) through her work with children involved in a school bus kidnapping in Chowchilla, California.

PTSD and the *DSM-III*

Psychological trauma and PTSD were not included in the *DSM* until 1980, when returning Vietnam War veterans presented with severe symptoms and clearly needed prolonged psychological services. Advocates for combat veterans and mental health professionals collaborated in bringing these events and their aftermath to public view (Herman, 1981, 1992; van der Kolk, Weisaeth, et al., 1996). Together with advocates of battered women, rape victims, and abused children, these clinicians brought their influence to bear on the *DSM-III* committees, and all of these groups were included under the diagnosis of PTSD in 1980. Veterans' advocates, mental health professionals, and others working with victims of domestic violence and adult survivors of childhood incest/sexual abuse reported similar symptoms in their traumatized clients. Many had been further victimized owing to social stigmata and a lack of understanding of their behavioral, emotional, and cognitive symptoms. In addition to advocating for the acceptance of PTSD diagnosis, women's

advocates opposed the inclusion of certain personality disorders that they regarded as being sexist and/or culturally biased, such as masochistic and histrionic personality disorders.

The *DSM* diagnosis of PTSD addressed immediate symptoms following combat experiences, rape, domestic violence, and child abuse; symptoms were then categorized along four clusters: intrusive reexperiencing, avoidance, hyperarousal, and hypervigilance, with general symptoms of anxiety and dysphoria in addition (Ford & Courtois, 2009). Although the PTSD diagnosis addresses the symptoms of posttraumatic stress, it does not focus on causes in a patient's early developmental history, which may include childhood abuse and neglect; nor does it offer a more complex and comprehensive view of psychosocial stressors and daily functioning that exert influence over all areas of adult life.

Complex Traumatic Stress Disorder

As stated above, although the diagnosis of PTSD included the comprehensive symptoms of trauma, it did not address early antecedents in childhood, the impact on long-term social and professional functioning, and the role of trauma in personality disorders. Herman (1992) was the first to suggest that "Complex PTSD" be included as a new diagnosis that would address the multiple origins of trauma and their impact on all aspects of a person's life. She noted that frequently, women with borderline personality disorder were marginalized by mental health professionals who failed to understand the connection between their early experience of sexual abuse and their present personality structure. More recently, Courtois developed the comprehensive diagnosis of complex trauma (Courtois, 2004, 2009), which she explains as the "inability to self regulate, self organize, or draw upon relationships to regain self integrity" (Ford & Courtois, 2009, p. 17). Complex trauma is "associated with histories of multiple traumatic stressors and exposure experiences, along with severe disturbances in primary care giving relationships" (Ford & Courtois, 2009, p. 18). It can lead to substance abuse, unemployment, and homelessness and affects all psychosocial aspects of living. A diagnosis of complex traumatic stress disorder calls for a treatment model that addresses the immediate posttraumatic symptoms as well as psychosocial counseling, substance abuse treatment, domestic violence interventions, and assistance in improving professional and interpersonal skills as well as in obtaining housing.

Developmental Trauma Disorder

Along with the recognition of complex traumatic stress disorder and its impact on all aspects of the person's life, van der Kolk (2005) recommended

the inclusion of a new diagnosis, which he called developmental trauma disorder, for children with complex developmental trauma histories. This diagnosis is distinct from other childhood diagnoses such as ADHD, oppositional defiant, and conduct disorder in that it specifically addresses the consequences of early trauma in relation to abuse and neglect. Van der Kolk noted that a study by Kaiser Permanente of 17,337 members revealed that 11% reported having been emotionally abused as children, 30.1% reported early physical abuse, and 19.9% reported sexual abuse (van der Kolk, 2005). This survey shows that childhood abuse is much more common than previously known and that those children deprived of intervention or treatment of early abuse symptoms will likely suffer from behavioral, emotional, and cognitive disturbances for the rest of their lives. In addition, early trauma affects the neurological development of young children, who may not be able to develop the neuronal structures necessary to process information, regulate emotions, and categorize experiences. This can lead to poor impulse control, aggression, difficulty in interpersonal relationships, and poor academic performance because of their inability to concentrate. In later development, such children may develop self-harming and substance abuse disorders in an effort to regulate their emotional arousal, owing to their difficulty in self-soothing and affect regulation. Van der Kolk suggested that multiple exposures to childhood traumas, including "abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence" (2005, p. 406) can have negative sequelae that continue to reverberate throughout childhood, adolescence, and adulthood.

Trauma in Contemporary Life

Traumatic stress has become more prevalent and complex in contemporary American life as a result of the mass trauma of 9/11, the ongoing war against terrorism, and ongoing wars in Iraq and Afghanistan, which have led to an increased incidence of PTSD in returning military personnel. In the immediate aftermath of 9/11, mental health professionals treated survivors based on the principles of critical incident stress debriefing procedures (Everly & Mitchell, 1999; Mitchell, 1983). This treatment approach is based on the assumption that encouraging expression of one's thoughts and feelings about the traumatic event soon after it happens will bring about relief and resolution of symptoms (Seery, Silver, Holman, Ence, & Chu, 2008). However, to date there are few data to show that expressing one's thoughts and feelings immediately after trauma is a good way of coping. Although some studies indicate that trauma expression results in better mental health, research has shown that the mean amount of time between the target event and the participant's disclosure is 15 months, well beyond the limits of early intervention (Frattaroli, 2006). A meta-analysis by van Emmerik, Kamphuis, Hulsbosch, and Emmelkamp (2002) shows that critical incident stress debriefing does not significantly improve PTSD and other trauma-related

symptoms such as general anxiety and depression. In addition, Sherman, Zanotti, and Jones (2005) found that survivors of 9/11 who chose not to discuss the trauma they experienced showed better mental health outcomes for 2 years after 9/11 than people who chose to express their feelings and discuss their experiences. As a result of these studies, trauma intervention methods have become less intrusive and are now based on stabilization and psychosocial approaches (Basham & Miehls, 2006; Briere & Scott, 2006; Ford & Courtois, 2009).

More recently, as a result of the wars in Iraq and Afghanistan, which have entailed multiple, long deployments for military personnel, the violent death of peers, and the high incidence of physiological and psychological trauma, the rates of complex PTSD have been increasing. Complex PTSD affects both these soldiers and their families and requires new intervention approaches. Prolonged exposure techniques (Foa, 2006; Foa et al., 2005) immediately following the event, although helpful to some patients, have been found to be far too intense for others. Moreover, the treatment dropout rate is quite high (K. Basham, personal communication, 2009). A phase-based approach that would include stabilization techniques, education, and social skills training may be more effective in helping these soldiers integrate their experiences, adapt to civilian life and to their role in their families, and return to productive lives (Ford & Courtois, 2009).

Contemporary Approaches to Trauma

In this volume, we have tried to include traumatized groups that are less familiar to professional audiences to contribute to the dissemination of new knowledge. The emphasis in this book is on clinical interventions with a number of specific communities. Although limitations of space have made it impossible to cover all contemporary treatments in this volume, we would like to mention the important role of body-based therapies, including somatic therapy (Levine) and sensorimotor psychotherapy (Fisher & Ogden, 2009). These therapies are particularly significant in trauma work, where experiences are frequently stored in nonverbal parts of the brain such as the amygdala and in sensory organs. Body-based therapies help clients access traumatic experiences that are not yet available for verbal narration and cognitive reflection. Many clients require processes other than talk therapy to make the material available to conscious awareness.

Sensorimotor therapy is influenced by several bodies of literature, including mindfulness practice, attachment theory, and neurobiology, particularly Schore's (2003) work on affect regulation, and also by Peter Levine's somatic therapy model (Levine, 1997). Although no formal research has been done on this model, there is clinical evidence of its usefulness with traumatized clients. The model focuses on both body and mind, but rather than focusing on verbal and analytical skills, the interaction of thought, feeling, bodily

sensation, and movement is emphasized through mindfulness observations of the "here and now." Sensorimotor therapists help clients

> regulate arousal by carefully tracking physical sensations for signs of dysregulation, by asking questions that direct attention to relationships between bodily response and narrative content, by teaching clients to recognize the physical signs that indicate dysregulated or hyperarousal, and by encouraging them to experiment with specific somatic interventions that promote regulation. (Fisher & Ogden, 2009, p. 317)

The therapist encourages the client to express experience through action and arm and bodily movements, which may be either protective or aggressive in nature. The therapeutic process includes phases of stabilization, memory and emotion work, and finally integration.

Another group of treatments showing promise with traumatized clients is mindfulness meditation–based therapies. Although these have not been specifically developed to address trauma, they have been effective in the management of stress, pain, and chronic and terminal illness. There has been much research on mindfulness-based therapy that has entered the health care field and is rapidly becoming part of a treatment protocol in hospitals and health care settings. Mindfulness therapies are inspired by Eastern meditation practices, and all share common elements. In addition to dialectical behavioral therapy, other mindfulness-based therapies have been developed and show promise in the treatment of borderline personality disorder, anxiety, depression, and pain management. To date, these models include dialectical behavioral therapy (Linehan, 1993a, 1993b), developed for borderline personality disorders; acceptance and commitment therapy (Hayes & Strosahl, 2004); mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002); and mindfulness-based stress reduction (Kabat Zinn, 1990, 2003, 2005).

The principles common to all of these models include the following:

- accepting internal experiences as they are, even when difficult, and observing them with curiosity, openness, and compassion;
- integrating mindfulness skills with change-based strategies, which suggests that although there is an attitude of patience and acceptance, there is also an emphasis on teaching skills for change (e.g., affect regulation and social skills); and
- decentering or defusion: observing experiences as transitory mental states, such that the client learns to recognize that thoughts and feelings pass and change and there is no need to immediately react or identify oneself with what one is thinking and feeling.

The goals of such treatment are increasing awareness of the present-moment experience, including sensations, thoughts, feelings, and environmental stimuli; cultivating an accepting nonjudgmental stance; reducing symptoms; developing

self-exploration and insight; developing wisdom and compassion; and finally, living in accordance with values such as love, compassion, integrity, and honesty (Baer & Huss, 2008). Unlike cognitive-behavioral therapy, mindfulness-based models advocate staying with states of mind, feelings, and physical sensations rather than using distraction strategies or restructuring thoughts and beliefs (cognitive restructuring). States of mind might include traumatic memories, physical pain and discomfort, negative thoughts, and intense feeling states. The client learns to allow, accept, and welcome mental states and bodily sensations without trying to fix them or change them.

Outline of the Book

In this book, we will address contemporary developments in the principal theoretical models that deal with trauma, including cognitive-behavioral, psychodynamic, and attachment theories. Although this volume is not intended to comprehensively address all populations and communities affected by various kinds of traumas, we have tried to select groups that the literature has not yet fully addressed. This book will include discussions of interventions with children who experienced 9/11 through the death of family members, adolescents who have been subjected to bullying, combat trauma, practice with traumatized gay men, and intergenerational trauma among Native Americans. Finally, the impact on the clinician and the implications for teaching and supervision will be discussed.

Although there has been much scholarship devoted to the study of trauma, the field has expanded rapidly during the past decade as a result of several significant developments. From an earlier focus on the interpersonal aspects of trauma, including child abuse and domestic violence, traumatic experiences have taken on political and social dimensions, for example, the events of 9/11, the war on terror, and combat trauma associated with recent wars in Afghanistan and Iraq. Finally, the rash of school shootings in American public schools, increasingly linked to the problem of bullying, has also recently entered the public consciousness. These complex social and political phenomena have added to the magnitude of traumatic experiences in everyday life and created a more challenging task for mental health professionals dealing with trauma and its aftermath. Accordingly, this volume will present new developments in the conceptualization of trauma and trauma-related interventions from diverse theoretical and clinical perspectives, with special attention to emerging clinical groups and populations.

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Psychological trauma

Psychological trauma is damage to a person's mind as a result of one or more events that cause overwhelming amounts of stress that exceed the person's ability to cope or integrate the emotions involved, eventually leading to serious, long-term negative consequences.[1] Trauma is not the same as mental distress.

Psychological trauma	
Specialty	Psychiatry, psychology

Given that subjective experiences differ between individuals, people will react to similar traumatic events differently. In other words, not all people who experience a potentially traumatic event will actually become psychologically traumatized.[2] However, some people will develop post-traumatic stress disorder (PTSD) after being exposed to a major traumatic event.[3] This discrepancy in risk rate can be attributed to protective factors some individuals may have that enable them to cope with trauma; they are related to temperamental and environmental factors from among others. Some examples are resilience characteristics and active seeking of help.[4]

Contents

Signs and symptoms

People who go through these types of extremely traumatic experiences often have certain symptoms and problems afterwards. The severity of these symptoms depends on the person, the type of trauma involved, and the emotional support they receive from others. The range of reactions to and symptoms of trauma can be wide and varied, and differ in severity from person to person. A traumatized individual may experience one or several of them.[5]

After a traumatic experience, a person may re-experience the trauma mentally and physically. For example, the sound of a motorcycle engine may cause intrusive thoughts or a sense of re-experiencing a traumatic experience that involved a similar sound (e.g., gunfire). Sometimes a benign stimulus (e.g., noise from a motorcycle) may get connected in the mind with the traumatic experience. This process is called traumatic coupling.[6] In this process, the benign stimulus becomes a trauma reminder, also called a trauma trigger. These can produce uncomfortable and even painful feelings. Re-experiencing can damage people's sense of safety, self, self-efficacy, as well as their ability to regulate emotions and navigate relationships. They may turn to psychoactive substances including alcohol to try to escape or dampen the feelings. These triggers cause flashbacks, which are dissociative experiences where the person feels as though the events are recurring. Flashbacks can range from distraction to complete dissociation or loss of awareness of the current context. Re-experiencing of symptoms is a sign that the body and mind are actively struggling to cope with the traumatic experience.

Triggers and cues act as reminders of the trauma and can cause anxiety and other associated emotions. Often the person can be completely unaware of what these triggers are. In many cases this may lead a person suffering from traumatic disorders to engage in disruptive behaviors or self-destructive coping mechanisms, often without being fully aware of the nature or causes of their own actions. Panic attacks are an example of a psychosomatic response to such emotional triggers.

Consequently, intense feelings of anger may frequently surface, sometimes in inappropriate or unexpected situations, as danger may always seem to be present due to re-experiencing past events. Upsetting memories such as images, thoughts, or flashbacks may haunt the person, and nightmares may be frequent.[7] Insomnia may occur as lurking fears and insecurity keep the person vigilant and on the lookout for danger, both day and night. Trauma doesn't only cause changes in one's daily functions, but could also lead to morphological changes. Such epigenetic changes can be passed on to the next generation, thus making genetics one of the components of psychological trauma. However, some people are born with or later develop protective factors such as genetics and sex that help lower their risk of psychological trauma.[8]

The person may not remember what actually happened, while emotions experienced during the trauma may be re-experienced without the person understanding why (see Repressed Memory). This can lead to the traumatic events being constantly experienced as if they were happening in the present, preventing the subject from gaining perspective on the experience. This can produce a pattern of prolonged periods of acute arousal punctuated by periods of physical and mental exhaustion. This can lead to mental health disorders like acute stress and anxiety disorder, traumatic grief, undifferentiated somatoform disorder, conversion disorders, brief psychotic disorder, borderline personality disorder, adjustment disorder, etc.[9]

In time, emotional exhaustion may set in, leading to distraction, and clear thinking may be difficult or impossible. Emotional detachment, as well as dissociation or "numbing out" can frequently occur. Dissociating from the painful emotion includes numbing all emotion, and the person may seem emotionally flat, preoccupied, distant, or cold. Dissociation includes depersonalisation disorder, dissociative amnesia, dissociative fugue, dissociative identity disorder, etc. Exposure to and re-experiencing trauma can cause neurophysiological changes like slowed myelination, abnormalities in synaptic pruning, shrinking of the hippocampus, cognitive and affective impairment. This is significant in brain scan studies done regarding higher-order function assessment with children and youth who were in vulnerable environments.

Some traumatized people may feel permanently damaged when trauma symptoms do not go away and they do not believe their situation will improve. This can lead to feelings of despair, transient paranoid ideation, loss of self-esteem, profound emptiness, suicidality, and frequently, depression. If important aspects of the person's self and world understanding have been violated, the person may call their own

identity into question.[5] Often despite their best efforts, traumatized parents may have difficulty assisting their child with emotion regulation, attribution of meaning, and containment of post-traumatic fear in the wake of the child's traumatization, leading to adverse consequences for the child.[10][11] In such instances, seeking counselling in appropriate mental health services is in the best interests of both the child and the parent(s).

Causes

Situational trauma

Trauma can be caused by human-made, technological and natural disasters,[12] including war, abuse, violence, mechanized accidents (such as vehicle accidents) or medical emergencies.

An individual's response to psychological trauma can be varied based on the type of trauma, as well as socio-demographic and background factors.[12] There are several behavioral responses commonly used towards stressors including the proactive, reactive, and passive responses. Proactive responses include attempts to address and correct a stressor before it has a noticeable effect on lifestyle. Reactive responses occur after the stress and possible trauma has occurred and is aimed more at correcting or minimizing the damage of a stressful event. A passive response is often characterized by an emotional numbness or ignorance of a stressor.

Those who are able to be proactive can often overcome stressors and are more likely to be able to cope well with unexpected situations. On the other hand, those who are more reactive will often experience more noticeable effects from an unexpected stressor. In the case of those who are passive, victims of a stressful event are more likely to suffer from long-term traumatic effects and often enact no intentional coping actions. These observations may suggest that the level of trauma associated with a victim is related to such independent coping abilities.

There is also a distinction between trauma induced by recent situations and long-term trauma which may have been buried in the unconscious from past situations such as childhood abuse. Trauma is sometimes overcome through healing; in some cases this can be achieved by recreating or revisiting the origin of the trauma under more psychologically safe circumstances, such as with a therapist. More recently, awareness of the consequences of climate change is seen as a source of trauma as individuals contemplate future events as well as experience climate change related disasters. Emotional experiences within these contexts are increasing, and collective processing and engagement with these emotions can lead to increased resilience and post traumatic growth, as well as a greater sense of belongingness. These outcomes are protective against the devastating impacts of psychological trauma. [13]

In psychodynamics

Psychodynamic viewpoints are controversial,[14] but have been shown to have utility therapeutically.[15]

French neurologist, Jean-Martin Charcot, argued in the 1890s that psychological trauma was the origin of all instances of the mental illness known as hysteria. Charcot's "traumatic hysteria" often manifested as paralysis that followed a physical trauma, typically years later after what Charcot described as a period of "incubation". Sigmund Freud, Charcot's student and the father of psychoanalysis, examined the concept of psychological trauma throughout his career. Jean Laplanche has given a general description

of Freud's understanding of trauma, which varied significantly over the course of Freud's career: "An event in the subject's life, defined by its intensity, by the subject's incapacity to respond adequately to it and by the upheaval and long-lasting effects that it brings about in the psychical organization".[16]

The French psychoanalyst Jacques Lacan claimed that what he called "The Real" had a traumatic quality external to symbolization. As an object of anxiety, Lacan maintained that The Real is "the essential object which isn't an object any longer, but this something faced with which all words cease and all categories fail, the object of anxiety *par excellence*".[17]

Fred Alford, citing the work of object relations theorist Donald Winnicott, uses the concept of inner other, and internal representation of the social world, with which one converses internally and which is generated through interactions with others. He posits that the inner other is damaged by trauma but can be repaired by conversations with others such as therapists. He relates the concept of the inner other to the work of Albert Camus viewing the inner other as that which removes the absurd.[18] Alford notes how trauma damages trust is social relations due to fear of exploitation and argues that culture and social relations can help people recover from trauma.[18]:49

Stress disorders

All psychological traumas originate from stress, a physiological response to an unpleasant stimulus.[19] Long-term stress increases the risk of poor mental health and mental disorders, which can be attributed to secretion of glucocorticoids for a long period of time. Such prolonged exposure causes many physiological dysfunctions such as the suppression of the immune system and increase in blood pressure.[20] Not only does it affect the body physiologically, but a morphological change in the hippocampus also takes place. Studies showed that extreme stress early in life can disrupt normal development of hippocampus and impact its functions in adulthood. Studies surely show a correlation between the size of hippocampus and one's susceptibility to stress disorders.[21] In times of war, psychological trauma has been known as shell shock or combat stress reaction. Psychological trauma may cause an acute stress reaction which may lead to posttraumatic stress disorder (PTSD). PTSD emerged as the label for this condition after the Vietnam War in which many veterans returned to their respective countries demoralized, and sometimes, addicted to psychoactive substances.

The symptoms of PTSD must persist for at least one month for diagnosis to be made. The main symptoms of PTSD consist of four main categories: trauma (i.e. intense fear), reliving (i.e. flashbacks), avoidance behavior (i.e. emotional numbing), and hypervigilance (i.e. continuous scanning of the environment for danger).[22] Research shows that about 60% of the US population reported as having experienced at least one traumatic symptom in their lives, but only a small proportion actually develops PTSD. There is a correlation between the risk of PTSD and whether or not the act was inflicted deliberately by the offender.[8] Psychological trauma is treated with therapy and, if indicated, psychotropic medications.

The term *continuous posttraumatic stress disorder* (CTSD)[23] was introduced into the trauma literature by Gill Straker (1987). It was originally used by South African clinicians to describe the effects of exposure to frequent, high levels of violence usually associated with civil conflict and political repression. The term is also applicable to the effects of exposure to contexts in which gang violence and crime are endemic as well as to the effects of ongoing exposure to life threats in high-risk occupations such as police, fire, and emergency services.

As one of the processes of treatment, confrontation with their sources of trauma plays a crucial role. While debriefing people immediately after a critical incident has not been shown to reduce incidence of PTSD, coming alongside people experiencing trauma in a supportive way has become standard

practice.[24]

Vicarious trauma

Vicarious trauma affects workers who witness their clients' trauma. It is more likely to occur in situations where trauma related work is the norm rather than the exception. Listening with empathy to the clients generates feeling, and seeing oneself in clients' trauma may compound the risk for developing trauma symptoms.[25] Trauma may also result if workers witness situations that happen in the course of their work (e.g. violence in the workplace, reviewing violent video tapes.)[26] Risk increases with exposure and with the absence of help seeking protective factors and pre-preparation of preventive strategies.

Diagnosis

As "trauma" adopted a more widely defined scope, traumatology as a field developed a more interdisciplinary approach. This is in part due to the field's diverse professional representation including: psychologists, medical professionals, and lawyers. As a result, findings in this field are adapted for various applications, from individual psychiatric treatments to sociological large-scale trauma management. While the field has adopted a number of diverse methodological approaches, many pose their own limitations in practical application.

The experience and outcomes of psychological trauma can be assessed in a number of ways.[27] Within the context of a clinical interview, the risk of imminent danger to the self or others is important to address but is not the focus of assessment. In most cases, it will not be necessary to involve contacting emergency services (e.g., medical, psychiatric, law enforcement) to ensure the individuals safety; members of the individual's social support network are much more critical.

Understanding and accepting the psychological state of an individual is paramount. There are many misconceptions of what it means for a traumatized individual to be in psychological crisis. These are times when an individual is in inordinate amounts of pain and incapable of self-comfort. If treated humanely and respectfully the individual is less likely to resort to self harm. In these situations it is best to provide a supportive, caring environment and to communicate to the individual that no matter the circumstance, the individual will be taken seriously rather than being treated as delusional. It is vital for the assessor to understand that what is going on in the traumatized person's head is valid and real. If deemed appropriate, the assessing clinician may proceed by inquiring about both the traumatic event and the outcomes experienced (e.g., post-traumatic symptoms, dissociation, substance abuse, somatic symptoms, psychotic reactions). Such inquiry occurs within the context of established rapport and is completed in an empathic, sensitive, and supportive manner. The clinician may also inquire about possible relational disturbance, such as alertness to interpersonal danger, abandonment issues, and the need for self-protection via interpersonal control. Through discussion of interpersonal relationships, the clinician is better able to assess the individual's ability to enter and sustain a clinical relationship.

During assessment, individuals may exhibit activation responses in which reminders of the traumatic event trigger sudden feelings (e.g., distress, anxiety, anger), memories, or thoughts relating to the event. Because individuals may not yet be capable of managing this distress, it is necessary to determine how the event can be discussed in such a way that will not "retraumatize" the individual. It is also important to take note of such responses, as these responses may aid the clinician in determining the intensity and severity of possible post traumatic stress as well as the ease with which responses are triggered. Further, it is important to note the presence of possible avoidance responses. Avoidance responses may involve the absence of expected activation or emotional reactivity as well as the use of avoidance mechanisms (e.g., substance use, effortful avoidance of cues associated with the event, dissociation).

In addition to monitoring activation and avoidance responses, clinicians carefully observe the individual's strengths or difficulties with affect regulation (i.e., affect tolerance and affect modulation). Such difficulties may be evidenced by mood swings, brief yet intense depressive episodes, or self-mutilation. The information gathered through observation of affect regulation will guide the clinician's decisions regarding the individual's readiness to partake in various therapeutic activities.

Though assessment of psychological trauma may be conducted in an unstructured manner, assessment may also involve the use of a structured interview. Such interviews might include the Clinician-Administered PTSD Scale,[28] Acute Stress Disorder Interview,[29] Structured Interview for Disorders of Extreme Stress,[30] Structured Clinical Interview for DSM-IV Dissociative Disorders- Revised,[31] and Brief Interview for post-traumatic Disorders.[32]

Lastly, assessment of psychological trauma might include the use of self-administered psychological tests. Individual scores on such tests are compared to normative data in order to determine how the individual's level of functioning compares to others in a sample representative of the general population. Psychological testing might include the use of generic tests (e.g., MMPI-2, MCMI-III, SCL-90-R) to assess non-trauma-specific symptoms as well as difficulties related to personality. In addition, psychological testing might include the use of trauma-specific tests to assess post-traumatic outcomes. Such tests might include the post-traumatic Stress Diagnostic Scale,[33] Davidson Trauma Scale,[34] Detailed Assessment of post-traumatic Stress,[35] Trauma Symptom Inventory,[36] Trauma Symptom Checklist for Children,[37] Traumatic Life Events Questionnaire,[38] and Trauma-related Guilt Inventory.[39]

Children are assessed through activities and therapeutic relationship, some of the activities are play genogram, sand worlds, coloring feelings, self and kinetic family drawing, symbol work, dramatic-puppet play, story telling, Briere's TSCC, etc.[40]

Definition

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines trauma as direct personal experience of an event that involves actual or threatened death or serious injury; threat to one's physical integrity, witnessing an event that involves the above experience, learning about unexpected or violent death, serious harm, or threat of death, or injury experienced by a family member or close associate. Memories associated with trauma are typically explicit, coherent, and difficult to forget.[41] The person's response to aversive details of traumatic event involves intense fear, helplessness or horror. In children it is manifested as disorganized or agitative behaviors.[42]

Trauma can be caused by a wide variety of events, but there are a few common aspects. There is frequently a violation of the person's core assumptions about the world and their human rights, putting the person in a state of extreme confusion and insecurity. This is seen when institutions depended upon for survival violate, humiliate, betray, or cause major losses or separations instead of evoking aspects like positive self worth, safe boundaries and personal freedom.[43]

Psychologically traumatic experiences often involve physical trauma that threatens one's survival and sense of security.[44] Typical causes and dangers of psychological trauma include harassment, embarrassment, abandonment, abusive relationships, rejection, co-dependence, physical assault, sexual abuse, partner battery, employment discrimination, police brutality, judicial corruption and misconduct, bullying, paternalism, domestic violence, indoctrination, being the victim of an alcoholic parent, the threat or the witnessing of violence (particularly in childhood), life-threatening medical conditions, and medication-induced trauma.[45] Catastrophic natural disasters such as earthquakes and volcanic

eruptions, large scale transportation accidents, house or domestic fire, motor vehicle accident, mass interpersonal violence like war, terrorist attacks or other mass victimization like sex trafficking, being taken as a hostage or being kidnapped can also cause psychological trauma. Long-term exposure to situations such as extreme poverty or other forms of abuse, such as verbal abuse, exist independently of physical trauma but still generate psychological trauma.

Some theories suggest childhood trauma can increase one's risk for mental disorders including post-traumatic stress disorder (PTSD),[46] depression, and substance abuse. Childhood adversity is associated with neuroticism during adulthood.[47] Parts of the brain in a growing child are developing in a sequential and hierarchical order, from least complex to most complex. The brain's neurons change in response to the constant external signals and stimulation, receiving and storing new information. This allows the brain to continually respond to its surroundings and promote survival. The five traditional signals (sight, hearing, taste, smell, and touch) contribute to the developing brain structure and its function.[48] Infants and children begin to create internal representations of their external environment, and in particular, key attachment relationships, shortly after birth. Violent and victimizing attachment figures impact infants' and young children's internal representations.[10] The more frequently a specific pattern of brain neurons is activated, the more permanent the internal representation associated with the pattern becomes.[49] This causes sensitization in the brain towards the specific neural network. Because of this sensitization, the neural pattern can be activated by decreasingly less external stimuli. Childhood abuse tends to have the most complications with long-term effects out of all forms of trauma because it occurs during the most sensitive and critical stages of psychological development.[4] It could also lead to violent behavior, possibly as extreme as serial murder. For example, Hickey's Trauma-Control Model suggests that "childhood trauma for serial murderers may serve as a triggering mechanism resulting in an individual's inability to cope with the stress of certain events."[50]

Often psychodynamic aspects of trauma are overlooked even by health professionals: "If clinicians fail to look through a trauma lens and to conceptualize client problems as related possibly to current or past trauma, they may fail to see that trauma victims, young and old, organize much of their lives around repetitive patterns of reliving and warding off traumatic memories, reminders, and affects."[51]

Treatment

A number of psychotherapy approaches have been designed with the treatment of trauma in mind—EMDR, progressive counting (PC),[52] somatic experiencing, biofeedback, Internal Family Systems Therapy, and sensorimotor psychotherapy, and Emotional Freedom Technique (EFT) etc.

There is a large body of empirical support for the use of cognitive behavioral therapy[53][54] for the treatment of trauma-related symptoms,[55] including post-traumatic stress disorder. Institute of Medicine guidelines identify cognitive behavioral therapies as the most effective treatments for PTSD.[56] Two of these cognitive behavioral therapies, prolonged exposure[57] and cognitive processing therapy,[58] are being disseminated nationally by the Department of Veterans Affairs for the treatment of PTSD.[59][60] A 2010 Cochrane review found that trauma-focused cognitive behavioral therapy was effective for individuals with acute traumatic stress symptoms when compared to waiting list and supportive counseling.[61] Seeking Safety is another type of cognitive behavioral therapy that focuses on learning safe coping skills for co-occurring PTSD and substance use problems.[62] While some sources highlight Seeking Safety as effective[63] with strong research support,[64] others have suggested that it did not lead to improvements beyond usual treatment.[62] Recent studies show that a combination of treatments involving dialectical behavior therapy (DBT), often used for borderline personality disorder, and exposure therapy is highly effective in treating psychological trauma.[8] If, however, psychological trauma has caused dissociative disorders or complex PTSD, the trauma model approach (also known as

phase-oriented treatment of structural dissociation) has been proven to work better than the simple cognitive approach. Studies funded by pharmaceuticals have also shown that medications such as the new anti-depressants are effective when used in combination with other psychological approaches.[65] At present, the selective serotonin reuptake inhibitor (SSRI) antidepressants sertraline (Zoloft) and paroxetine (Paxil) are the only medications that have been approved by the Food and Drug Administration (FDA) in the United States to treat PTSD.[66] Other options for pharmacotherapy include serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressants and anti-psychotic medications, though none have been FDA approved.[67]

Trauma therapy allows processing trauma-related memories and allows growth towards more adaptive psychological functioning. It helps to develop positive coping instead of negative coping and allows the individual to integrate upsetting-distressing material (thoughts, feelings and memories) and to resolve these internally. It also aids in the growth of personal skills like resilience, ego regulation, empathy, etc.[68]

Processes involved in trauma therapy are:

- Psychoeducation: Information dissemination and educating in vulnerabilities and adoptable coping mechanisms.
- Emotional regulation: Identifying, countering discriminating, grounding thoughts and emotions from internal construction to an external representation.
- Cognitive processing: Transforming negative perceptions and beliefs about self, others and environment to positive ones through cognitive reconsideration or re-framing.
- Trauma processing: Systematic desensitization, response activation and counter-conditioning, titrated extinction of emotional response, deconstructing disparity (emotional vs. reality state), resolution of traumatic material (in theory, to a state in which triggers no longer produce harmful distress and the individual is able to express relief.)
- Emotional processing: Reconstructing perceptions, beliefs and erroneous expectations, habituating new life contexts for auto-activated trauma-related fears, and providing crisis cards with coded emotions and appropriate cognition. (This stage is only initiated in pre-termination phase from clinical assessment and judgement of the mental health professional.)
- Experiential processing: Visualization of achieved relief state and relaxation methods.

A number of complementary approaches to trauma treatment have been implicated as well, including yoga and meditation.[69] There has been recent interest in developing trauma-sensitive yoga practices,[70] but the actual efficacy of yoga in reducing the effects of trauma needs more exploration.[71]

In health and social care settings, a trauma informed approach means that care is underpinned by understandings of trauma and its far-reaching implications.[72] Trauma is widespread. For example, 26% of participants in the Adverse Childhood Experiences (ACEs) study[73] were survivors of one ACE and 12.5% were survivors of four or more ACEs. A trauma-informed approach acknowledges the high rates of trauma and means that care providers treats every person as if they might be a survivor of trauma.[72] Measurement of the effectiveness of a universal trauma informed approach is in early stages [74] and is largely based in theory and epidemiology.

Trauma informed teaching practice is an educative approach for migrant children from war-torn countries have typically experienced complex trauma, and the number of such children entering Canadian schools has led some school jurisdictions to consider new classroom approaches to assist these pupils.[75][76] Along with complex trauma, these students often have experienced interrupted schooling due to the migration process, and as a consequence may have limited literacy skills in their first language.[77] One study of a Canadian secondary school classroom, as told through journal entries of a

student teacher, showed how Blaustein and Kinniburgh's ARC (attachment, regulation and competency) framework[78] was used to support newly-arrived refugee students from war zones.[75] Tweedie et al. (2017) describe how key components of the ARC framework, such as establishing consistency in classroom routines; assisting students to identify and self-regulate emotional responses; and enabling student personal goal achievement, are practically applied in one classroom where students have experienced complex trauma. The authors encourage teachers and schools to avoid a deficit lens to view such pupils, and suggest ways schools can structure teaching and learning environments which take into account the extreme stresses these students have encountered.[75]

See also

- Comfort object
- Emotion and memory
- Existential crisis
- Grief
- Hypervigilance
- Identification with the aggressor
- Posttraumatic growth
- Psychogenic pain
- Psychological pain
- Screen memory
- Trauma model
- Trauma Systems Therapy
- Unthought known
- Somatic experiencing

Specific:

- Betrayal trauma
- Historical trauma
- Rape trauma syndrome
- Remote location stress reaction
- Transgenerational trauma
- Vicarious traumatization

Psychosomatic impact:

- Complex post-traumatic stress disorder
- Psychoneuroimmunology
- Psychosomatic medicine
- Stress (medicine)
- Thousand-yard stare

Physical:

- Physical trauma
- Traumatology

Psychotraumatologists:

- Gottfried Fischer

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- Michael Terry (1999), *Kelengakutelleghpat: An Arctic community-based approach to trauma* (https://www.researchgate.net/publication/232526894)

External links

- Psychological abuse (https://curlie.org/Health/Mental_Health/Psychological_Abuse/) at Curlie
- The International Society for Traumatic Stress Studies (ISTSS) (http://www.istss.org/)
- Trauma-Focused Cognitive Behavioral Therapy – Medical University of South Carolina (https://tfcbt.musc.edu/)
- National Child Traumatic Stress Network (NCTSN) (http://www.nctsn.org/)
- Trauma Information Pages (http://www.trauma-pages.com/)

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PARTIAL ARTICLE

Dance/Movement Therapy: A Whole Person Approach to Working with Trauma and Building Resilience

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Abstract

This paper explores the use of dance/movement therapy, as a Whole Person approach to working with trauma and building resilience, to effect individual and community change around the world. The arts are a particularly effective way for people who cannot express themselves verbally to find symbolic and embodied expression of their suffering and hopes for the future. Dance/movement therapy can draw on folk dance and specific cultural forms to address universal themes. The content of this paper was presented as a workshop at the American Dance Therapy Association convention in San Diego, 2015.

Introduction: How Does Art Heal?

The arts heal from the basic human need to create, communicate, create coherence, and symbolize. They are symbolic representations of human experience, usually visual, kinesthetic (dance), verbal (poetry), or musical (song, music). They are transcultural, expressing archetypal symbols that are universal throughout history and across cultures. In an age of increased interconnectedness, we are challenged by natural and manmade disasters from around the globe. The clash of cultures brings misunderstandings and conflict. The arts can "help us search again not only for the meaning of life but also the purpose of our individual and collective experience…for ways we might re-create ourselves anew as a human species, so that we may end at last the cycle of violence that has marred our history "(Walsh, 2001, p. 17).

The arts provide symbolic nonverbal ways to work with unspeakable trauma, natural and manmade disasters, dislocation and caregiver burnout. Building on creativity, they facilitate posttraumatic growth (Tedeschi & Calhoun, 1996; Serlin & Cannon 2004), growth through adversity (Joseph & Linley, 2008), hardiness (Maddi & Hightower, 1999), optimism and resilience (Antonovsky, 1979; Epel et al, 1998)

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and self-efficacy. Used to build resiliency in a Whole Person context (Serlin, 2007a, 2010a, b, c), they bring together body, speech, mind and spirit.

The arts heal by improving immune functioning and reducing stress and health complaints, and help people live longer (Pennebaker, 1990). Increasingly, studies have demonstrated the relationship between stress and the body, including the relationship between negative emotions and the fight/flight response, cortisol levels, hypertension and Type A personalities (Babette, 2006; Schore, 1994). Positive emotions also impact wellness including hope, curiosity, and a positive expectation about the future. Finally, stress is not the same for all people, but is individually and subjectively mediated by perceptions, beliefs and cognitions (Serlin, 2006a).

The arts provide access to multiple modes of intelligence (Gardner, 1982), thinking, communicating, and problem solving (Briere & Spinazzola, 2005), connecting us to the imagination (McNiff, 1981), and bridging the conscious and the unconscious. They take us into expanded states of consciousness, helping us understand our waking reality, mindfulness, altered states and dreamtime. And, in many cultures, art takes us into the realm of ritual and the sacred (Graham-Pole, 1997; Marcow Speiser, 1995, 1998; Marcow Speiser and Speiser, 2005, 2007; Serlin, 1993, 1996a, 2012a; Sonke-Henderson, 2007). Facilitating creativity, compassion and connectedness, new contexts and new frames of reference, the arts help each person to discover his or her personal strengths and preferred channel of communication (Carey, 2006; Haen, 2009; Harris, 2007; Levine, 2009; Serlin, 2007b, 2010a).

Stories of death and rebirth descend into sadness and ascend to joy. Disconnection and reconnection are ancient themes reflected in the myths common to all humankind (Serlin, 1993). With the courage to create (May, 1975), new narratives move the self from deconstruction to reconstruction (Feinstein & Krippner, 1988; Gergen, 1991; McAdams et al, 1997; Sarbin, 1986). These healing narratives are experienced as coherent and meaningful and have been gaining attention in many areas of clinical practice, including family therapy (Epston & White, 1992; Howard, 1991; Lieblich & Josselson, 1997; Omer & Alon, 1997; Polkinghorne, 1988). The act of telling stories has always helped humans deal with the threat of nonbeing, and sometimes the expressive act itself has a healing effect (Pennebaker, 1990; Serlin, 2012a, b, c). It expresses not only the individual person, but also the collective unconscious and universal states of the human condition (Jung, 1966).

Art heals by helping us transcend our stuck places and imagine a future or a different situation. The arts are used in rituals around the world for individual and communal healing. Spiritually based rituals have been shown to be effective coping strategies for dealing with life stresses (Pargament, 1997; Marcow Speiser, 1995, 1998) and serious trauma (Frankl, 1959). Art opens doors to the religious and spiritual dimensions of human nature and human fate, which are ultimate questions that are central to an integrative whole person healthcare (Sue, Bingham, Porche-Burke, & Vasquez, 1999).

Art helps us create in the face of these ultimate questions. Rollo May reminds us that the creative act is a courageous affirmation of life in face of the void of death (Maslow, 1962; May, 1975; Serlin & Hansen, 2015). Trauma brings a confrontation with mortality that can lead to the creation of a new identity, sense of meaning, beliefs, existential choice and a renewed will to live (Serlin, 2002; Stolorow, 2007).

Through art, through the telling and re-telling of their stories, people can rediscover meaning, gain a sense of efficacy and re-create themselves (Paulson & Krippner, 2007; Yalom, 1980).

From Destruction to Reconstruction: The Path of Resilience

What is resilience? Resilience is the capacity to bounce back after stress and trauma, to rebuild a life even after devastating tragedy. Being resilient doesn't mean going through life without experiencing stress and pain. Grief, sadness, and pain are natural after adversity and loss (Herman, 1992). The road to resilience lies in working through the emotions and effects of stress and painful events and learning from them. Reflecting on adversity can increase a sense of meaning, purpose and compassion in life. Meeting challenges with creativity can widen horizons and possibilities.

Resiliency includes many dimensions. The arts and narrative methods express and record life stories (Gergen, 1991; May, 1975, 1989; Sarbin, 1986) and facilitate healing (Pennebaker, 1990) within a community of witnesses (Marcow Speiser, 2014). Qualities that build resiliency include optimism, joy and compassion. The use of the arts and particularly dance/movement, builds resilience at the body level.

What brings resiliency? Resiliency grows with enhanced self-management skills and more wisdom. It is helped by supportive relationships with parents, peers and others, as well as through cultural beliefs and spiritual traditions. Developed across the lifespan, resiliency is marked by close relationship with family and friends, a positive view of oneself and confidence in one's strengths and abilities, the ability to manage strong feelings and impulses, and good problem-solving and communication skills. Additionally, the ability to seek help and find resources, seeing oneself as resilient rather than as a victim, coping with stress in healthy ways and avoiding harmful coping strategies, helping others, and finding positive meaning in life despite difficult or traumatic events is helpful.

Domains of Resiliency

For an online support group used in workshops in Silicon Valley and with youth groups for high school students going into healthcare professions, Dr. Laleh Shahidi, Dan Esbensen and this author developed the following four domains of resiliency as composite descriptions from many definitions of resiliency (www.selfresiliency.com):

Physical

Kinaesthetic intelligence includes the ability to keep one's balance, to clarify boundaries, to read the messages from one's body, to take stretch breaks while working, and to be aware of one's nonverbal communication to others.

Psychological

From a cognitive perspective, resiliency means the ability to see the glass as half full, and to know deeply who one is. From an emotional perspective, it means the ability to support and love oneself, to be able to self-soothe and self-regulate, and to feel and express one's emotions.

Social

The social domain of resiliency includes the relational ability of forming and sustaining attachments, enjoying satisfying intimate relationships, and creating a healthy support system. Also included are the environmental aspects of respecting and enjoying nature and one's community.

Meaning and Purpose

The existential aspect of meaning and purpose includes the ability to confront mortality and to live a life of commitment and authenticity. The spiritual aspect can mean having a "calling", and a sense of meaning and belonging larger than oneself. The transcendent aspect is the ability to feel at home in the universe (Serlin, 2010, summer).

Resilience from a Whole Person Perspective

A Whole Person (Serlin, 2001–2002, 2007a, b, c) perspective on resiliency brings together mind, body and spirit in an integrated healthcare model with a focus on meaning and purpose, wellness, strengths, creativity and humor.

Whole Person Healthcare is built on a new vision of a fully-actualizing person first articulated by Abraham Maslow, former president of APA: "There is now emerging over the horizon a new conception of human sickness and of human health…Perhaps we shall soon be able to use as our guide and model the fully growing and self-fulfilling human being, the one in whom all his potentialities are coming to full development, the one whose inner nature expresses itself freely." In 2001, the American Psychological Association added "health" to its mission statement, and this author convened a panel at the APA convention on the subject (De Leon et al, 1998). In 2004, she was part of an APA Task Force on Health Care for the Whole Person, and in 2006 part of one from Division 42 of APA. The question of what it means to be human can be understood from the Humanistic Psychology perspective on identity, beliefs, and existential issues; from the creative arts therapy perspective of imagery, art, dance music drama, poetry, and journaling; from a somatic psychology perspective including qigong, tai chi, aikido, Feldenkrais, movement, EMDR, EFT and yoga, and a spiritual perspective that includes meditation, mindfulness awareness, stress reduction and prayer.

A Whole Person psychotherapy embraces diverse approaches that include nonverbal and multi-modal modalities such as expressive therapies and mindfulness meditation (Shapiro & Walsh, 1984), cultural beliefs about living and dying (Sue et al, 1999), opening healthcare to diverse, disabled, and marginalized populations. A Whole Person model offers new ways of cultivating resourcefulness and nurturing a growth mindset.

Whole Person approaches to psychotherapy include: can be grouped into three areas: (1) Meditation or mindfulness (Shapiro & Walsh, 1984); (2) Imagery including guided imagery, KinAesthetic imagery (Serlin, 1996), and verbal imagery (Serlin, Rockefeller & Fox, 2007); (3) Movement including dance movement therapy (Serlin, 2010a, b, c), qigong, yoga, Feldenkrais, Alexander, and somatic therapies.

Movement is a whole person approach that helps clarify and release the stress, countertransference and burnout carried by both caregiver and the person in need of care. The kind of approach used by this author is a process of dance/movement therapy called Kinaesthetic Imagining. Kinaesthetic imagery comes from the Greek word "kinaesthesia" (Gr.), the sensations and expressions arising from bodily movement that become a nonverbal expressive text (Serlin, 1996). By learning to listen to our bodily signals, we can understand better how to care for ourselves and others. Kinaesthetic Imagery has three basic components: Warm-up and check-in, using breath, sound, stretching and circle dance movements to warm up the body and mobilize the healing energies; Body Language includes the development of the themes to explore images and emotions that arise from the movement, individually, in dyads, and in the group so that participants have an opportunity to develop their own personal healing images, stories, and mythologies; and Reflection (Action Hermeneutics) as a time to wind down, internalize the imagery, and reflect on its meaning in order to make a transition into real life.

Posttraumatic Growth

> *Without a bit of sadness a beautiful samba cannot be made* (Vinicius de Morais & Baden Powell)

The concept of resilience is closely tied to a new theory called Posttraumatic growth (PTG) (Calhoun & Tedeschi, 2006). Instead of focusing on restoring personal and communal functioning to premorbid levels of functioning, as is done in traditional trauma recovery, the theory of posttraumatic growth suggests that from the break-down of trauma can come break-through, and that further growth is possible (Lev-Weisel & Amir, 2006; Rosner & Poswell, 2006).

Reflecting on the fact that posttraumatic growth might seem too positive, Stephen Joseph and Alex Linley from proposed a theory called "Growth Following Adversity" (2008). Proponents of this theory value the learning that comes from adversity and bring this dimension into the therapy.

Both Posttraumatic Growth and Growth following Adversity support an approach that builds resiliency by going through stages of destruction to reconstruction. The

arts have an important role to play here as they help people re-imagine and re-energize their lives.

Secondary Trauma

The arts can also play a large role to help with secondary trauma; the trauma that caregivers experience after prolonged exhaustion from caregiving. Caregivers also experience what psychologist Charles Figley called "compassion fatigue" (1995). Even in non-combat situations such as families living with elders who have dementia or Alzheimer's, these caregivers need help. The arts can facilitate resilience, self-care, care-giver satisfaction and compassion regeneration from a whole person relational and client-centered perspective. This toolkit, that includes mindfulness, imagery and movement, was developed by the author to help caregivers with a form of burnout called "Compassion Fatigue" (Serlin, 2012b) (Fig. 1).

Whole Person Approaches to Trauma and PTSD

Whole Person approaches to working with trauma and building resilience include all dimensions: existential, embodied, creative and mindful. Recent research tells us that *trauma is in the body* (Levine, 1997; Ogden et al, 2006). Trauma has been

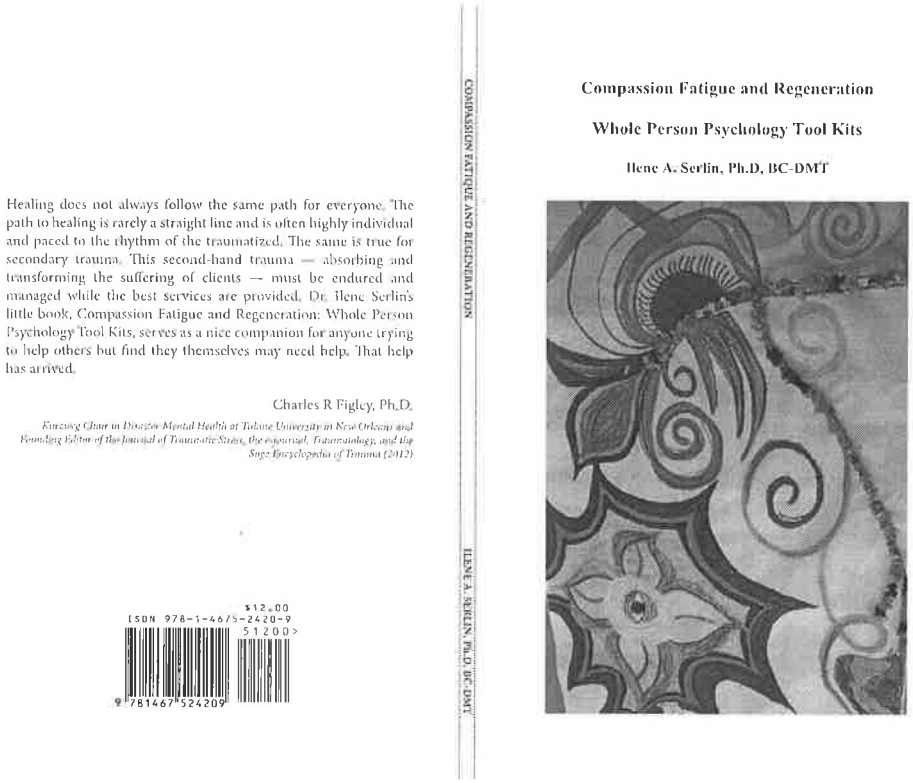

Fig. 1 Compassion fatigue and regeneration

called by Bessel Van der Kolk "speechless terror;" therefore, approaches need to utilize nonverbal, symbolic methods (Van der Kolk, 2014; Serlin, 2015). Trauma is a crisis of mortality, meaning and identity; therefore, approaches need to cover existential and spiritual perspectives. Trauma is about "stuckness" and "numbness" and the inability to play; therefore, approaches that are creative, imaginal, moving

Fig. 2 Dance therapy, creativity, and self-care workshop

to hide and cover the real scope of the event and the attitude towards the community who are not allowed to grieve and express their feelings ... There is lot to scream. On, death and rebirth theme now, there is so much death around us...but still need to feel the hope for the rebirth of a new potential life or era.

In Istanbul, we trained healthcare professionals at Safir Institute, a training program that is now at Mimar Sinan University. Students have begun applying The Art of Embodiment training to work in psychiatric hospitals, nursing homes, with breast cancer and hematology units in general hospitals (Fig. 8).

The training in Beijing took place at the China Institute of Psychology, where students are taking the training back to their hometowns. In Hong Kong, the training took place at the University of Hong Kong in a master's program in Expressive Therapies at the Centre on Behavioural Health. Masters students in the program work with situations of child abuse, domestic violence, and life-threatening illnesses (Fig. 9).

The world is increasingly interconnected, and in need of powerful healing responses to trauma and human suffering. Dance Movement Therapy is one trauma approach that can address this suffering. Reaching across cultures, it can be shared in global training settings.

Compliance with Ethical Standards

Conflict of interest The author declares that the author has no conflict of interest

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Ilene A. Serlin Ph.D, BC-DMT is a licensed psychologist and registered dance/movement therapist in practice in San Francisco and Marin county. She is the past president of the San Francisco Psychological Association, a Fellow of the American Psychological Association, past-president of the Division of Humanistic Psychology. Ilene Serlin is Associated Distinguished Professor of Psychology at the California Institute of Integral Studies, has taught at Saybrook University, Lesley University, UCLA, the NY Gestalt Institute and the C.G. Jung Institute in Zurich. She is the editor of *Whole Person Healthcare* (2007, 3 vol., Praeger), over 100 chapters and articles on body, art and psychotherapy, and is on the editorial boards of *PsycCritiques*, the *American Dance Therapy Journal,* the *Journal of Humanistic Psychology*, *Arts & Health: An International Journal of Research, Policy and Practice, Journal of Applied Arts and Health,* and *The Humanistic Psychologist.* In 2019, she received the Rollo May award from APA's Society for Humanistic Studies, and the California Psychological Association Distinguished Humanitarian Contribution award.

10 Steps to Living In Alignment with the Universe

This simple guide will help you to live in greater partnership with the Universe around you. by Dr. Jean Houston

By **Evolving Wisdom** - February 2, 2021

This is based on the wonderful list, "Spiritually Literate New Year's Resolutions" created by Frederic and Mary Ann Brussat, though I've re-envisioned it to be used year-round for anyone wanting to live a Quantum Life.

Say aloud and in your heart's mind (and mind's heart) the following:

1. I live in the present moment. I will not obsess about the past or worry about the future. I know that with quantum practice I have access to entering and making whatever changes I wish in the worlds of past and future, for I live in the eternal present."

2. I cultivate the art of making connections—cosmic connections, local connections. I pay attention to how my life is intimately related to all life. I become the friend of nature and preserve her beauty and harmony wherever and whenever I can.

3. I am thankful for all the blessings in my life. I spell out my days with the grammar of gratitude. I speak forth my gratitude: "Thank you for this food and all who worked to bring it forth. Thank you, Grandma, wherever you are, for teaching me how to cook."

4. I practice hospitality in a world where too often strangers are feared, enemies are hated, and the other is shunned. I see no one as other. I welcome guests and even people with very different ideas from mine with graciousness, with deep seeing of the fullness and wonder of the other.

5. I seek liberty and justice for all. I will work for a free and a fair world, a world that works for everyone.

6. I add to the planet's fund of goodwill by practicing little acts of kindness, brief words of encouragement, and manifold expressions of courtesy.

7. I cultivate the skills of deep listening. I will cross the great divide of otherness. I remember that all things in the world want to be heard, as do the many voices inside of me.

8. I practice reverence for life by seeing the sacred in, with, and under all things of the world. Everything exists within the field of the sacred.

9. I give up trying to hide, deny, or escape from my imperfections. I listen to what my shadow side says, but I will not just live there. I know that I am releasing many of these old forms, these old shadows, and I am bringing in light to banish shadow and to bring me into luminous light and life.

10. I am willing to learn from the spiritual teachers all around me, however unlikely or unlike me they may be.

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Moving On journal: Special Issue: Focus on Dr. Marcia B. Leventhal Volume 11, No. 1-2

Edited by Jane Guthrie with Naomi Aitchison and others

This collection of writings by Dr. Marcia Leventhal includes reprints of historic articles, and some articles not previously published. It includes writings on the influences that led to Dr Leventhal's strong views about the essential nature of dance as a therapy; the impact she had on the development of dance therapy and the emergence of dance therapy in Australia. The issue also contains the history of the successful dance movement therapy training program that Dr. Leventhal set up in Australia that can be read about in contributions from Tony Norquay and Jennifer Helmich.

There are also writings by others about her work and reminiscences from friends, colleagues and students, including Iris Rifkin-Gainer, Patricia Capello, Jane Wilson Cathcart, Anne Marie Ruta Buchanan and Professor M. Linda Graham from the USA. Jenny Czulak Riley, Elizabeth Loughlin, Elizabeth Mackenzie, Jane Refshauge, Naomi Audette and Fran Ostroburski are some of the contributors from Australia, along with Gerry Harrison and Amanda Kougioufa from the UK, and Nina Alkalay from Greece. The volume is generously illustrated with many photographs from Dr. Leventhal's career as a dancer, actor, therapist and dance therapy educator. This impressive record of one of the pioneers of dance movement therapy would make a valuable addition to the collection of anyone interested in the history of dance movement therapy education and practice.