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**"There's no escaping the body" : clinicians' views on the relevance of the body and the use of body-based interventions in work with mother-child dyads exposed to domestic violence**

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Danielle Sachs  
“There’s No Escaping The Body”:  
Clinicians’ Views on the Relevance  
of the Body and the Use of Body-  
Based Interventions in Work with  
Mother-Child Dyads Exposed to  
Domestic Violence

### **ABSTRACT**

The purpose of this exploratory, descriptive study was to examine if and how clinicians working with mother-child (0-5) dyads exposed to domestic violence perceived the body as being a part of treatment: Did they perceive the body as being a part of treatment; did they then make use of specific body-based interventions, and how were those interventions defined?

Eleven clinicians participated in qualitative interviews to provide their perspectives on the relevance and integration of the body in dyadic clinical work focused on the attachment between mother child dyads exposed to domestic violence. Participants -- comprised of licensed and provisionally licensed mental health professionals in practice for at least five years (including MFT’s, PhD’s, LCSW’s, and Professional Counselors) -- were asked open-ended questions about their general perspectives on the use of the body and physical touch in dyadic treatment; specific questions targeting their use of touch/physical interaction as well as which interventions they used, if any, they defined as explicitly body-based.

While participants provided varying responses about the relevance of the body, all participants found an understanding of and attention to the body as being relevant to their work. Additionally, all eleven participants identified self-defined body-based interventions that they employed in their attachment-based clinical practice with violence exposed mother-child dyads.

**“THERE’S NO ESCAPING THE BODY”:  
CLINICIANS’ VIEWS ON THE RELEVANCE OF THE BODY AND THE USE OF  
BODY-BASED INTERVENTIONS IN WORK WITH MOTHER-CHILD DYADS  
EXPOSED TO DOMESTIC VIOLENCE**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work

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2012

## **ACKNOWLEDGEMENTS**

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## **CHAPTER I**

### **Introduction**

The primary purposes of this project were: first, to explore in personal interviews with a small group of clinicians working with mother-child dyads exposed to domestic violence the ways in which they perceive the body as being a part of treatment with this particular population, if they do; and second, to learn from them how/if they make use of body-oriented interventions. Attachment, trauma, and somatic theories served as the foundational underpinnings of this study. This project attempted to unite the significant advancements made in these fields over the last two decades. Despite evident overlapping themes in literature on attachment, trauma, and the body in mental health, there appeared to be a deficiency in research that drew out and highlighted these specific overlapping elements. In particular, there was only a small base of primarily anecdotal literature that drew attention to the links between the body/body-based interventions and the practice of dyadic psychotherapy with mothers and children. However, as the developments in research on attachment and trauma have made clear, the body (specifically neurobiology and physiology) is indeed an essential element of the mind's internalization of attachment, the attachment relationship itself, and a person's individual reaction to trauma. Thus, this project attempted to elicit answers to questions such as: Do dyadic clinicians from varying clinical orientations define the body as evident in or important to attachment and trauma? If they do in fact see the body as being a part of these things, how do they see body-oriented strategies as being a part of treatment interventions? And, if they understand the body as important in

chosen interventions, what are the specific interventions they identify as being body-based? This study purposively interviewed clinicians with varying clinical orientations and differing preferences in intervention models, but with the common characteristic of treating the attachment between mothers and children aged zero to five. As domestic violence is far from being the only issue causing ruptures in the attachment relationship, these clinicians treated caregiver and child/infant dyads with a variety of contributing problems. However, interviews in the current study focused on these clinicians' experiences with cases involving domestic violence as a primary issue.

Domestic violence is a widespread and serious issue. The deleterious effects of physical, emotional, and sexual violence on a victimized partner within an intimate relationship are perhaps self-evident, but also have been widely studied and documented. Women experiencing domestic violence can have a higher incidence of health issues, low self-esteem, depression, trauma symptoms, impaired social and professional functioning, and are at greater risk for serious physical injury or death (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). Additionally, a child's witnessing domestic violence and the subsequent social, emotional, cognitive, and health effects on these secondary victims has been a major point of interest for researchers (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Children exposed to domestic violence have displayed higher levels of anxiety, aggression, anger, withdrawal, depression, low self-esteem, compromised peer relationships, lower cognitive functioning, difficulties in academic performance, higher levels of adult depression and trauma symptoms, and are at an increased risk for child maltreatment (Wolfe et al., 2003).

While the effects of domestic violence on mothers and children as individuals was foundational in the project, the context of the research conducted was the effect of domestic



violence on the *attachment relationship between* a mother who has been abused by an intimate partner and her young child who directly or indirectly witnessed the violence.

Studies have found that maternal exposure to domestic violence can affect the quality of parenting (Lieberman, Van Horn, & Ghosh Ippen, 2005); that the presence of domestic violence can cause disruptions in infants' and children's early attachments (Levendosky, Huth-Bocks, & Bogat, 2011; Zeanah, Danis, Hirshberg, Benoit, Miller, & Heller, 1999), and that parent-child support and therapeutic intervention to develop or restore secure attachment are primary needs of children exposed to domestic violence (Lundy & Grossman, 2005)

Over the last two decades, as psychotherapy with young children has gone through a substantial and continuous progression, children five years of age and younger are generally treated in psychotherapy along side their primary caregiver (Gallo, 1997). It is during the early years that the attachment relationship, the quality of which serves as a possible protective/risk factor in a child's resiliency after trauma, is being formatively shaped. When there are disturbances to the relationship between mother and child during this crucial time, such as the presence of domestic violence in the home, the child's sense of self, sense of safety, and ability to self-regulate can become compromised. Thus, it has been the primary focus of mental health professionals treating young children to address the child's relationship with its highly influential primary caregiver. Infant/child and caregiver dyadic therapy has its roots in the work of therapists such as Selma Fraiberg, who developed infant-parent psychotherapy. It has evolved to include a variety of modalities and interventions that treat both caregiver and child together. Interventions from a variety of clinical orientations have developed in order to treat caregivers and young children together including, but not limited to, Child-Parent Psychotherapy (Lieberman, 2007), Parent-Child Interaction Therapy (developed by Sheila Eyberg and

colleagues: see for example, Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998), Theraplay (Munns, 2011), and Attachment and Biobehavioral Catch-up (Dozier, Peloso, Lindheim, Gordon, Manni, Sepulveda, & Ackerman, 2006).

As various types of attachment-based therapeutic modalities have developed to address both trauma experienced by mother and child (domestic violence being just one of these traumas) and the resulting impairments in the attachment relationship, advancements in technology and a growing interest in the physiology of mental health have led to new developments in the understanding of how the body and brain are inextricably linked to attachment and trauma.

Advances in neuroscience and neuroimaging techniques have contributed to an increase in knowledge regarding the neurobiology of attachment and trauma (Divino & Moore, 2010). Key neurobiological concepts informing a growing recognition of the physiology of mental health have emerged from research in this area. We now know that experiences in infancy and early childhood activate particular neuro-biochemical reactions that either develop or block gene expression (Divino & Moore, 2010). This has been called “neuroplasticity,” and essentially means that experience shapes the structure of the brain (Divino & Moore, 2010; Perry, Pollard, Blakely, Baker, & Vigilante, 1995).

Research on the right hemisphere of the brain has also led to new ways of conceptualizing attachment and early trauma. This interdisciplinary research has found that early attachments are crucial to the growth of the neurobiological structure of the right hemisphere of the brain, which controls what Schore and Schore (2007) called, “. . .the functional origins of the bodily-based implicit self” (p. 10). Research has affirmed the importance of early attachment on right-brain development based on findings that the right hemisphere (responsible for emotional processing, stress modulation, and self-regulation) is the only fully functional side of the brain at

birth and remains dominant for the first two to three years of life (Divino & Moore, 2010; Schore & Schore, 2007). Therefore, infants and toddlers are developing patterns of emotional communication far before the development of verbal skills, which are based in the left hemisphere of the brain. Additionally, neuroscientific research has determined that it is precisely the neurobiology of attachments that produces internal working models, or templates, for later relationships (Divino & Moore, 2010; Schore & Schore, 2007). Moreover, this research has shown that early trauma disrupts the integration of the right and left hemispheres of the brain due to constant triggering of the fear-response system in the young child's body (Divino & Moore, 2010; Perry et al., 1995). Essentially, early experiences of the world and relationships become encoded in non-verbal channels (Divino & Moore, 2010; Perry et al., 1995; Siegel, 2001).

As research supporting the relevance of neurobiological and physiological processes in attachment and trauma has expanded, it has been argued that incorporating the body into therapeutic intervention is an increasingly important part of mental health treatment. Pioneers in child trauma research and treatment, such as Bruce Perry and Bessel van der Kolk, have endorsed the importance of integrating both attachment and somatic theory and intervention in relational models of therapy treating children in early childhood (Perry et al., 1995; Streeck-Fischer & van der Kolk, 2000). Others have directly endorsed the use of touch between caregiver-child dyads with problems in attachment as an essential part of treatment (Dozier, Higley, Albus, & Nutter, 2002; Field, 2010; Lucier, 2007). However, Leijssen (2006) contended that the body can be validated in psychotherapy in varying ways, including “the body sensed from the inside, the body perceived from the outside, the body in action, in movement, and other non-verbal expression, and/or the body in physical contact with another body, usually by touch” (p. 128).

The following literature review will present key theories and research on domestic violence, attachment, and the effects of trauma, threaded together by physiological and neurobiological concepts. Specific attention is paid to literature examining the efficacy of using touch between caregiver/child pairs. Additionally, literature identifying and examining the body in clinical practice through the use of elements such as dance and touch will be presented.

## CHAPTER 2

### Literature Review

#### Attachment

The attachment relationship in mother-child dyads has multiple functions for an infant. One of the fundamental functions of attachment is the regulation of affect and arousal in infants (Cassidy, 2008; Davies, 2011). Siegel (2001) offered that along with genetics, early interpersonal experiences have a direct influence on the development of the human brain.

The pioneering work of John Bowlby and Mary Ainsworth confirmed attachment as crucial to infant development (Cassidy, 2008; Marvin & Britner, 2008). Bowlby's work served as the foundation for attachment theory, which ascertained that infants' relationships to their mothers were based on more than just the need for food and basic safety; infants' seeking of close physical proximity to their mothers was based in their need to maintain a sense of security (Cassidy, 2008). He believed that attachment and bonding were innate needs of an infant. Subsequent research, such as that of Mary Ainsworth, further developed attachment theory to delineate specific patterns of secure and insecure attachment (Cassidy, 2008; Davies, 2011; Marvin & Britner, 2008). While the work of Bowlby and Ainsworth still holds relevance today, new ways of conceptualizing attachment have emerged. With advances in neuroscience and technology, researchers and clinicians not only confirmed the importance of attachment and bonding, but have expanded our understanding of attachment as an intricate neurobiological process (Divino & Moore, 2010; Schore & Schore, 2007) Schore and Schore (2007) contended:

In line with Bowlby's fundamental goal of the integration of psychological and biological models of human development, the current interest in affective bodily-based processes, interactive regulation, early experience-dependent brain maturation, stress, and nonconscious relational transactions has shifted attachment theory to a regulation theory (p. 10).

Thus, Schore and Schore (2007) purported that the attachment relationship is developed from the "...brain/mind/body of both infant and caregiver held within a culture and environment that supports it or threatens it" (p. 10).

Schore and Schore (2007) and Siegel (2001), among other researchers and theorists, have discussed the importance of understanding the role of the right hemisphere of the brain in developing attachment, and more specifically, the neurobiological basis of the attachment process. While the left hemisphere of the brain is involved in more logical, linear functions, the right hemisphere of the brain is involved in self-soothing actions, regulating bodily processes, affective expression and perception, and provides a more integrated basis for the somatosensory system, or representation of the body in the brain (Siegel, 2001). The right hemisphere of the brain is more dominant during the first few years of a child's life; and, further, the areas of the brain in the right hemisphere that regulate bodily function and emotionally attuned communication appear to be actively developing during this time (Schore & Schore, 2007; Siegel, 2001). Therefore, the ways in which the caregiver communicates with and attunes to the child during these crucial years may help to shape the right hemisphere's capacity for self-regulation, interpersonal relationships, sense of self, and the capacity to create and hold the mental representations of others as well as of the self (Siegel, 2001).

As early attachment needs initially present themselves as body-based needs, shared interactions between the primary caregiver and baby form the foundation of the attachment relationship through the caregiver's "...consistent and accurate attunement and response to the

infant's body" (Ogden, Minton, & Pain, 2006, p 44). In the mother-infant dyad, the mother serves as the moderator of her infant's arousal states calming baby when arousal is high and stimulating baby when arousal is low (Schore, 2001). The caregiver's providing of containment, through soothing the infant's body with touch and voice, serves to cultivate the baby's self-regulation (Ogden et al., 2006; Schore & Schore, 2007). These interactions, which are collaborative between the caregiver and child, are essential for the social and emotional development of an infant's/child's experientially influenced brain (Siegel, 2001).

Beebe, Lachmann, and Jaffe (1997) identified the attachment relationship as a mutual, mainly non-verbal process between caregiver and infant that involves non-verbal, self-regulatory and co-regulatory processes. Thus Beebe et al. (1997) stressed that the quality of the individual's self-regulatory capacity affects the functioning of dyadic regulation (Beebe et al., 1997). The primarily non-verbal interactions become the basis for how infants come to know and recognize their primary caregiver, as well as the nature of the attachment relationship (Beebe et al, 1997).

In line with Beebe et al. (1997), Siegel (2001) stated:

We can propose that within the child's brain is created a multisensory image of the emerging caregiver's non-verbal signals...it is in this manner that emotionally attuned communication, the resonant sharing of non-verbal signals, allows for the child to 'feel felt' and to create a secure attachment with that connecting adult (p. 84)

In a longitudinal, qualitative study on co-regulation in mother-child dyads, Evans and Porter (2009) found that co-regulated patterns between caregiver and infant were related to attachment development. The overall sample of this study consisted of 101 mothers and their first-born infants. Participants were recruited from local birth announcements, pediatric practices, and through local advertising. A limitation to the study was the lack of diversity in the sample, as 94% of participants were white and well educated. Nevertheless, Evans and Porter

(2009) found that the emergence of co-regulated patterns of communication likely influenced not only the attachment relationship, but also the emerging self-regulatory patterns of the pre-verbal infant. The researchers observed participants in laboratory play sessions and studied qualitative features of joint patterns of communication between mother and infant using the Relational Coding System. They also used Ainsworth's Strange Situation paradigm in order to study the attachment between mother-child dyad participants, as well as conducted qualitative interviews with mothers when their babies were six, nine, and twelve months old. Evans and Porter (2009) ultimately determined that regardless of how the infants respond to their mothers' cues, it was the mothers' attunement and responsiveness to the child that affected the security of the mother-infant relationship.

The significance of attachment cannot be overestimated, as the research discussed above provides evidence of the non-verbal, biological/neurobiological basis of attachment and co-regulation. Thus the importance of the body in these foundation processes of development is established.

### **The Mother-Child Dyad in the Context of Domestic Violence**

The impact of domestic violence is far-reaching and profound for women and children individually and for the mother-child dyad (Lieberman, 2007). For children, witnessing domestic violence can have an acute effect on self-regulation and emotional social, and cognitive functioning (Lieberman, Van Horn, & Ghosh Ippen, 2005). For mothers who are victims of domestic violence, parenting can become a difficult task, as feelings of fear, frustration, helplessness, and guilt arise (Appleyard & Osofsky, 2003). Appleyard and Osofsky (2003) explained, "When parents live in a state of constant fear and helplessness, their children often lack a sense of basic trust and security needed for healthy emotional development" (p. 113).



In a longitudinal study of the effects of domestic violence on the attachment relationship between mother and child, beginning during pregnancy, Levendosky, Bogat, Huth-Bocks, Rosenblum, and von Eye (2011a) found that the presence of domestic violence, beginning while mothers were pregnant, negatively impacted the attachment patterns of the mothers' children. In this study, women were first interviewed during pregnancy, and then interviewed yearly when the children were one to four years old. Levendosky, Bogat, and Huth-Bocks (2011b) later asserted that for mothers who have experienced domestic violence, traumatic memories and affects may fail to be integrated into normal functioning: thus, when the mother experiences a threat, the traumatic memories may interfere in usual caregiving responses. Furthermore, Levendosky et al., (2011a) posited that experiencing domestic violence during pregnancy relates to mothers developing maternal mental representations that are more likely distorted or disengaged. These authors also proposed that "...domestic violence is an assault on the caregiving system – it triggers helplessness and fear (often unconsciously) regarding psychological and physical integrity, dysregulating an individual's emotional and behavioral processes" (p. 516). Levendosky et al., (2011a) further offered that in the context of domestic violence, an infant's/child's distress may become a posttraumatic trigger, in turn making it a challenge for the emotionally dysregulated mother to be attuned to her baby. Exposure to domestic violence thus takes a toll on parents' ability to be a source of security and a safe base for their children (Levendosky et al, 2011a; Levendosky, 2011b; Lieberman, 2007; Appleyard & Osofsky, 2003). Lieberman (2007) explained, "For infants, toddlers, and preschoolers who rely on the attachment figure as the provider of predictability and protection, the first causalities of exposure to violence are the child's reliable expectations about what is safe and what is dangerous" (p. 427). Additionally, maternal exposure to violence has been linked to physical

abuse of children, as mothers who are victims of domestic violence at the hands of their partners may in turn become more harshly punitive with their children (Lieberman et al., 2005).

Lieberman et al., (2005) asserted that battered women may not only underestimate the impact of violence on their children due to guilt and/or diverted attention away from children and toward their own experience, but also may be triggered into avoidance by their child's behaviors.

In the context of domestic violence, the attachment relationship between the mother-child dyad can become compromised, while also simultaneously serving as a potential protective factor in child witnesses resiliency after domestic violence (Johnson & Lieberman, 2007). In a mixed method study of children exposed to domestic violence, Davies, Harold, Goeke-Morey, & Cummings (2002) found that the parent-child relationship serves as a potential mediator in the connection found between marital conflict and children's emotional dysregulation. Nevertheless, the realities of living with the threat of domestic violence make it difficult for non-offending parents to serve as mediators for their children (Lieberman, 2007). Lieberman (2007) elucidated, "Themselves frightened and uncertain, the parents may be unable to detect the anxiety underlying the child's aggression and incapable of providing reassurance while setting clear standards for permissible and impermissible child behavior" (p. 427).

In a longitudinal, descriptive, qualitative study using interviews with mothers, Levendosky, Leahy, Bogat, Davidson, and von Eye (2006) examined maternal mental health and infants' externalizing behaviors in the context of domestic violence. Participants were recruited through contact with women's health clinics, social services programs, childbirth classes, legal agencies, and domestic violence shelters. The researchers conducted two separate interviews with mothers, one in the third trimester of pregnancy, and one when the baby was one year old. Externalizing behaviors exhibited by infants were reported by the mother and not directly

observed by the researchers, which was a limitation of this study. To participate in this study women were required to be between and 18 and 40 years of age, in their third trimester of pregnancy, and involved in a romantic relationship of at least six weeks duration during their pregnancy. A group of mothers who were not victims of domestic violence was used for comparison. Levendosky et al. (2006) found that both past and present domestic violence influenced a woman's functioning, which in turn was correlated to higher levels of externalizing behaviors in infants.

Other qualitative studies have found that battered women and their children are more likely to demonstrate disorganized and other types of insecure mother-child relationships (Quinlivan & Evans, 2005; Zeanah et al., 1999; Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). In a study of 72 low-income mothers and their 15 month-old infants, Zeanah et al. (1999) found a strong link between high-risk mothers' reports of domestic violence and infant attachment. Zeanah et al. (1999) ascertained through their research that with increasing levels of violence in their current relationships, the occurrence of infants with disorganized attachments to their mothers notably increased. Zeanah et al. (1999) noted that this may have had to do with exposure to domestic violence as well as the presence of child maltreatment, as child maltreatment has been found to more likely occur in homes with domestic violence.

In an observational qualitative study with mother-child dyads exposed to domestic violence, Levendosky et al. (2003) found that preschool-aged children of battered women displayed a higher incidence of insecure attachments to their mothers than did children of non-battered women. This was indicated by fewer positive interactions, fewer verbal interactions, and farther physical proximity between domestic violence-exposed mothers and children observed by

Levendosky et al. (2003). The sample for this study was highly diverse in participants' education levels, incomes, and ethnicities.

Given the crucial role that attachment plays in child development and the subsequent evidence of impairments in parent-child relationships in the context of domestic violence, it becomes essential that the mother-child dyad be a primary focus of therapeutic interventions with this population (Borrego, Gutow, Reicher, & Barker, 2008; Johnson & Lieberman, 2007; Lieberman, 2007; Lundy & Grossman, 2005). In a study of over 40,000 children exposed to domestic violence, Lundy and Grossman (2005) compiled data collected over a five-year period from caregivers (99.5% being women) who entered domestic violence shelters between 1990 and 1995. Of children studied, 31.5% were one to two years of age and 27.9% were three to five years of age (the remaining 40.4% were six to twelve years of age). The service needs of children exposed to domestic violence were studied through interviews with and surveys of both parents and shelter staff. The fact that children themselves were not interviewed presents a possible limitation to this study. Nevertheless, this study examined social, emotional, health, and educational problems in order to evaluate the service needs of these children. Among their findings about the service needs of these domestic violence-exposed children, Lundy and Grossman (2005) reported that 80.6% of one to two year olds, 78.7% of three to five year olds, and 77.9% of six to twelve year olds, were found to be in need of parent-child support. Lundy and Grossman (2005) noted that many of the problematic behaviors found in these children's social, emotional, physical, and educational functioning have also been historically identified and linked to disruptions in attachment. Thus, Lundy and Grossman (2005) proposed that given the importance of secure attachments in resiliency, coupled with their research findings that the majority of parents and children studied were in need of parent-child support – assessment and

intervention around issues of attachment needed to be an explicit focus in treating children exposed to domestic violence.

### **The Body in the Context of Trauma**

Much like the attachment process between mother and child, the experience of trauma is fundamentally grounded in the body and neurobiological processes. When human beings are faced with threat, they employ both physical and psychological defenses that allow them to evaluate the situation and reduce stress in order to maximize chances of survival (Ogden & Minton, 2000). Perry et al. (1995) asserted that increasing threat alters not only the individual's mental state and cognition, but also physiology. Similarly, van der Kolk (1996) affirmed that intense emotional reactions to trauma are stored as visceral sensations, thus creating physiological changes in the body (van der Kolk, 1996). Solomon and Heide (2005) explained that ordinary or mildly disturbing events are processed by the brain, temporarily stored in the limbic system, and ultimately transferred to the frontal lobes for long-term storage. Traumatic experiences however, tend to overwhelm the brain's capacity to process information, and the traumatic experience may be stored indefinitely in the right limbic system. The lack of integration of the traumatic experience may produce vivid images of the experience, as well as frightening thoughts sensations, tastes, and smells (Solomon & Heide, 2005). The continued experiencing of the traumatic event causes the stress-response system to be repeatedly activated, resulting in dysregulation of social, cognitive, and emotional functioning (Ogden & Minton, 2000; Perry et al. 1995; Solomon & Heide, 2005; van der Kolk, 1996). When in a constant fear state, the traumatized individual becomes easily moved from being mildly anxious to feeling threatened, to feeling terrorized (Perry et al., 1995).

Perry et al. (1995) identified a threat continuum of calm to arousal, alarm, fear, and terror. They explained that the more threatened individuals are, the more primitive their thinking and behaving become, giving way to either a hyperarousal (fight or flight) or dissociative (freeze) response (Perry et al., 1995). In the face of perceived threat or danger, the sympathetic nervous system signals the brain to release hormones affecting multiple body systems, which in turn lead to a fight or flight response. However, if neither fight nor flight is possible, which is often the case for young children, the person will freeze (Ogden & Minton, 2000; Perry et al., 1995; Solomon & Heide, 2005; van der Kolk, 1996). Perry et al. (1995), in extensive clinical work with traumatized children, found that children will more often make use of a dissociative response as opposed to hyperarousal (Perry et al., 1995). Perry et al. (1995) found that children make use of a combination of responses to traumatic events. An initial hyperarousal response in the early stages of threat is designed to bring caregivers to defend the young child. However, if the threat continues, the child moves into the dissociative continuum, becoming immobile, compliant, and ultimately, completely dissociated (Perry et al., 1995). While both adults and children are affected by traumatic experiences on a neurobiological level, and may employ hyperarousal and/or dissociative responses to threat, Perry et al. (1995) ascertained that the implications of trauma may be indelibly distinct for infants/children due to the malleability of an infant's or young child's brain. Perry et al. (1995) stated:

Although experience may alter the behavior of an adult, experience literally provides the organizing framework for an infant and child. Because the brain is most plastic (receptive to environmental input) in early childhood, the child is most vulnerable to variance of experience during this time (p. 276).

Supporting this claim, DeBellis, Keshavan, Clark, Casey, Giedd, Boring...& Ryan (1999) produced evidence in brain imaging studies that brains of children who are subjected to trauma

are smaller, have larger corpus collosums between the two hemispheres, and are underdeveloped in the prefrontal cortex while overdeveloped in the hypothalamus as compared to others. Correspondingly, Perry et al. (1995) have found that traumatized children experience over-activation of essential neural systems (Perry et al. 1995, p. 277).

Perry et al. (1995) identified the presence of a healthy caretaker to provide support and nurturing as being an essential mitigating factor in diminishing the alarm response continuum to dissociative response in a young child following a traumatic event. However, Perry and his colleagues further noted that this becomes complicated if the caretaker was also traumatized. Perry et al. (1995) explained, “Through their persisting anxiety and inability to contain their persisting hyperarousal symptoms, the primary caretakers build into their children a mirroring hyperarousal fear response – a form of vicarious traumatization” (p. 285). The scenario that Perry and his colleagues outline here is certainly a potential reality for a mother experiencing, and a child simultaneously witnessing, domestic violence. Thus, if the physiological changes in the body due to trauma are not addressed both for the child and for the mother, the ability for healthy co-regulation and development of a secure attachment becomes a much more difficult task.

### **The Body in Treatment of Mother-Child Dyads**

In discussing trauma and child development, Streeck-Fischer and van der Kolk (2000) asserted the importance of using body-based interventions, or body-focused psychotherapy, in working with traumatized children. They explained that mastery is a primarily physical experience and involves “...the feeling of being in charge, calm and able to engage in focused efforts to accomplish the goals one sets for oneself” (p. 914). However, traumatized children are often in a state of hyperarousal or numbing and have difficulty tolerating trauma-related bodily

sensations and emotional states (Perry et al., 1995; Streeck-Fischer & van der Kolk, 2000) Thus, involving the body in treatment of traumatized children becomes essential. Streeck-Fischer and van der Kolk (2000) contended, “[Body-focused therapy] is necessary to help the child stay physically focused, to interpret his or her somatic feedback reactions and to tolerate physical sensations without becoming hyperaroused and impulsive, or freezing” (p. 914). Streeck-Fischer and van der Kolk (2000) spoke specifically about the relevance of the body in understanding traumatized children as well as how the body becomes essential in treatment of these children. However, within the context of the wounded attachment resulting from exposure to domestic violence, both child *and* parent are potentially experiencing similar hyperarousal or numbing bodily states. Because attachment is essentially a co-regulatory process between two beings, impairments in both individuals’ ability to self-regulate affects not only the individuals, but also the lived relationship between the two (Beebe et al., 1997; Devereaux, 2008).

In exploring the role of neurobiology in attachment relationships, Siegel (2001) stated, “The patterns in the flow of energy and information, the essence of the mind, are a product of both bodily (neurophysiological) processes and interpersonal interactions” (p. 70). Tortora (2010) spoke to this connection between bodily process and interpersonal interactions within the context of working with parent-child dyads. Tortora (2010) offered that the importance of addressing the body when working with parents and children dyadically is that a human being’s earliest experiences are processed on a somatic and sensorial level; thus, “body oriented experiences influence all levels of development, shaping how an infant makes sense of the world” (p. 40). Tortora (2010) and Siegel (2001) thus elucidated the importance of not only working with mothers and young children dyadically, but also of paying attention to the body and bodily processes while treating the attachment relationship.



Perhaps one of the most explicit ways of incorporating the body into the treatment of the attachment between mothers and children in early childhood who have been exposed to domestic violence is the use and encouragement of touch. In infancy, touch is a necessity and is an integral part of bonding and attachment (Durana, 1998; Field, 2010). Loving, nurturing touch produces oxytocin and releases endogenous opioids (both known to solidify infant-mother bonds), decreases blood pressure and heart rate, and decreases cortisol (stress hormone) levels (Field, 2010; Panksepp, 2001).

Empirical research has validated the importance of touch in mother-infant interaction and bonding, as well as healthy development of the infant. Cohn and Tronick's (1987) still-face/face-to-face episode created an important basis for studies establishing the importance of maternal attuned availability in mother-infant dyads (Moreno, Posada, & Goldyn, 2006). Cohn and Tronick's (1987) still-face/face-to-face measure involved a mother who was face-to-face with her infant displaying a passive or depressed facial expression alternated with playful/animated expressions and sounds, in order to elicit co-regulated, interactional patterns with her infant (Cohn & Tronick, 1987). While initial studies did not directly measure touch (Moreno et al., 2006), later studies (Gusella, Muir, & Tronick, 1988; Stack & Muir, 1992; Stack & LePage, 1996) found that infants smiled more, vocalized more, made more eye contact, grimaced less, and protested less in still-face interactions during which touch was allowed, compared to earlier studies where no touch was used in still-face episodes (Moreno et al., 2006). These studies also showed that maternal touch mitigated infants' stress responses to physical separation or brief periods of adult emotional unavailability (Moreno et al., 2006.) In a study of 79 women and their three and a half month-old infants, Moreno et al. examined whether touch enhanced co-regulation between mother-infant dyads; this research studied presence versus absence of touch

in non-stressful face-to-face (not still-face) interactions between mother and infant. The findings were that when touch was prohibited, relaxed mutually attuned (asymmetrical) co-regulation decreased. The study also found that symmetrical co-regulation (active interaction) increased during no-touch periods. The authors hypothesized that perhaps infants' and mothers' increase in active co-regulation was related to overcompensation due to the lack of touch. It is important to note that the sample for this study lacked diversity: 89% of participants were white and median income was \$70,000 (Moreno et al. 2006).

Integrating the effect of touch on the psyche as well as the body, Lucier (2007) explained:

It is also important that the mother connect to her infant from one body to another through the utilization of the senses of touch, smell, taste, sight, and sound, creating, through the skin, the defining boundary between internal and external space, forever impacting psychological development. These early sensorial encounters then become the basis for our experience of self and identity (Lucier, 2007, p. 123)

The topic of touch within psychotherapy is a controversial one (Durana, 1998; Leijssen, 2006). However, most of the taboo associated with the use of touch within psychotherapy is associated with touch between the therapist and the client. Within the context of attachment-based therapy with mother-child dyads, the dyad presents a different opportunity for touch, with physical touch being primarily between parents and child, and touch between therapist and client(s) being potentially unnecessary (Lucier, 2007).

### **Illustrations of Body-Based Interventions in Dyadic Treatment within Clinical Practice**

While there is a dearth of empirical research specifically focusing on the integration of the body or use of touch in treatment of mother-child dyads exposed to domestic violence, it is alive and well in clinical practice. The integration of the body in treatment spans numerous therapeutic modalities and interventions, including mindfulness training, breathing exercises,

awareness and acknowledgment of bodily states and movements, desensitization techniques, and the use of touch. Some specific models of integrated body and parent-child approaches to treating mother-child dyads include infant massage (Cooper, Ludwig, & Heineman, 2008; Lucier, 2007), Theraplay (Munns, 2011), dance therapy (Coulter & Loughlin, 1999; Tortora, 2010), and specific manualized interventions such as Attachment and Biobehavioral Catch-up (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008).

Suzie Tortora, creator of the Ways of Seeing program, describes her method of working with parent-child dyads as incorporating "...the knowledge of the important roles of multi-sensory, sensorimotor experience and play in early childhood development to support children enduring painful/traumatic experience... .Ways of Seeing is relationship-based, with the strength of the emotional body being paramount" (p. 40). The Ways of Seeing program uses physically oriented, non-verbal activities to address the parent and child's attachment system. Activities used with parents and children in the program include music, song, movement/dance, play, breath awareness, relational methods, and are used in conjunction with trauma techniques such as systematic desensitization (Tortora, 2010).

Another integration of body-based interventions with parent-child dyads is infant massage. Fostering Mindful Attachments is a program that works with parents of infants who are in, or at risk of, foster care placement (Cooper et al., 2008). The directors of the program, Amy Cooper, MFT, and Mark Ludwig, LCSW have created a curriculum that teaches infant massage as the foundation for teaching attunement and supporting the attachment relationship. Their method is focused on cognitive, emotional, sensory, relational, and arousal patterns. Cooper et al. (2010) explained, "Through practice, caregivers learn to track infants' responses to quality of

touch and interactions, as well as to recognize and attend to their own internal states of arousal” (p. 17).

Theraplay is a structured play therapy intervention for children and parents that aims to support and improve attachment, self-esteem, trust, and engagement (Munns, 2011; [www.theraplay.org](http://www.theraplay.org)). Theraplay specifically focuses on engaging parents and children in attuned and nurturing activities through the use of facial expression, voice, rhythm, touch, and physical presence as a way to elicit feelings from the child ([www.theraplay.org](http://www.theraplay.org)). Theraplay focuses explicitly on non-verbal communication, understanding and appreciation of the body in treatment, and the physiological basis of the relationship between parents and children. Theraplay also makes specific use of touch in treatment with dyads, further illustrating its appreciation and use of the body. The founders of Theraplay specifically outline various types of touch that are encouraged in treatment: structuring touch, engaging touch, nurturing touch, and calming/containing touch ([www.theraplay.org](http://www.theraplay.org)). The Theraplay model uses touch not only between therapist and clients but also between parents and children.

While the integrative approaches described above are supported by the writers’/clinicians’ use of case studies and previous research, there is a shortage of empirical research supporting the efficacy of the body-oriented, relational approaches to working with caregivers and children. There has however, been empirical research on specific attachment intervention models that do encourage body-based elements and the use of touch as an element of treatment with caregiver-child dyads. Dozier, Higley, Albus, and Nutter (2002) began developing interventions that addressed the needs of foster children/infants. Dozier and her co-authors identified three components comprising basic lacks impinging on foster children/infants in new caregiver homes: a child’s failure to elicit nurturance, caregivers’ discomfort in providing

nurturance, and behavioral, emotional, and neuroendocrine dysregulation (Dozier et al., 2002). While Dozier and her colleagues' research specifically related to foster children in foster homes, the three components the research identified reflect some of the difficulties, related to attachment, that children and mothers experience within the context of domestic violence. Like other relational, attachment-based models, the Attachment and Biobehavioral Catch-up (ABC) intervention developed by Dozier, essentially focused on treating the effects of early relationship disturbances on children's development (Dozier, Peloso, Lindheim, Gordon, Manni, Sepulveda, & Ackerman, 2006) through dyadic work with caregivers and children. Because of the biobehavioral effects of attachment disruptions, as well as the potential of secure attachment serving as a protective/buffering factor against trauma and stress, Dozier and her colleagues considered that therapeutic sessions targeting attachment security would also improve children's regulatory capacities (Dozier et al., 2008). The ABC intervention helps foster parents provide an atmosphere for foster children between the ages of zero to three that increases regulatory abilities, teaches the caregivers to follow the child's lead, and helps them to allow children to express, recognize, and understand emotions. Another essential subcomponent of the ABC intervention is teaching caregivers to appreciate the value of physical interaction, which increases behavioral and biobehavioral regulation (Dozier et al., 2006). This encouragement of psychical interaction, touching, hugging, and cuddling is accomplished through psychoeducation and the use of lap games supporting touch, such as "this little piggy," while maintaining attunement to the child's cues (Dozier et al., 2002; Dozier et al., 2006). The effectiveness of Dozier's ABC intervention has been empirically evaluated through the study of infants' and toddlers' production of cortisol, a stress hormone (Dozier et al., 2006; Dozier et al., 2008). Dozier et al. (2008) tested the cortisol levels of 46 children who completed the ABC

intervention, 47 children who completed an educational intervention, and 48 children who were not in the foster care system and did not receive any type of intervention. Researchers evaluated children's and caregivers' attachment through use of Ainsworth's Strange Situation. Caregivers were trained to collect saliva samples upon arrival at the laboratory, 15 minutes after completion of the Strange Situation, and 30 minutes after the Strange Situation. A subset also collected saliva samples from the children before they went home, and two hours after returning home. The results of the study showed that children whose caregivers had taken part in the relational intervention (ABC) had lower levels of cortisol when they arrived at the lab for the Strange Situation than the children whose caregivers participated in the educational intervention. A significant finding was that the children who had never been in foster care had lower levels of cortisol than foster children in the educational intervention control group, but similar levels of cortisol as children in the ABC intervention group (Dozier et al., 2008). Dozier et al. (2008) explained that these results indicated that, "... a relational intervention can affect the biology of infants and toddlers in foster care" (Dozier et al., 2008, p. 853).

While the research discussed here focused on foster children, Dozier et al. (2008) asserted that the findings in this study have implications for the study of stress neurobiology more generally (Dozier et al., 2008, p. 856). Furthermore, the findings of this research support the efficacy of relational interventions for dyads with attachment disruptions that also have a stated focus on the biological (as well as behavioral) impact of trauma and which subsequently use body-based interventions such as touch.

The literature just summarized shows that attachment-focused, body-based interventions currently are clearly on track to become a mainstay of work with dyads exposed to domestic violence. However, the relative paucity of empirical research related to this topic suggested to

me that an exploratory/descriptive study asking clinicians working with such dyads in therapeutic efforts today, could be helpful in illuminating the state of some such works' understanding about various theoretical and practical matters associated with their client-centered work.

## **CHAPTER 3**

### **Methodology**

A qualitative, flexible research method design was used to gather and analyze data from clinicians of varying clinical orientations working dyadically with mothers and children who have experienced domestic violence. The research question explored was: What are clinicians' perspectives on the relevance of the body and the use of body-oriented interventions in the treatment of the attachment relationship between mother-child dyads exposed to domestic violence? This was a cross-sectional, exploratory/descriptive qualitative study designed to obtain information on an integrative topic not sufficiently represented in academic literature or empirical research.

### **Sample**

Eleven clinicians were interviewed between October-April 2012; nine were female and two were male. The racial/ethnic make-up of study participants included six Caucasians, two Latinos, two African Americans, and one identified as Middle Eastern. Participants were between the ages of 35 and 62. The study was limited to English speaking, licensed or provisionally licensed clinicians who had current or past experience working dyadically with mothers and children exposed to domestic violence. Seven participants were Licensed Clinical Social Workers, two were Licensed Marriage and Family Therapists (one of whom was also a certified drama therapist), one was a Clinical Psychologist, and one was a provisionally licensed



Counselor. A table detailing each participant’s training discipline, additional training, and clinical orientation follows:

Table 1

Participant Training Discipline/Additional Training/Clinical Orientation

PARTICIPANT	TRAINING DISCIPLINE/ CLINICAL ORIENTATION
1	MFT/ Somatic and Drama Therapy, Trained in Sensorimotor Psychotherapy and Infant Massage
2	PhD, Clinical Psychologist/ Infant Mental Health, Attachment Framework, Family Systems, Child Exposure to Violence, Trained in Sensorimotor Psychotherapy and Child-Parent Psychotherapy
3	LCSW/ Early Childhood Mental Health, Attachment Framework
4	LCSW/Child Play Therapy, EMDR, Psychoanalytic Training in Relational Models and Self Psychology, Child Exposure to Domestic Violence
5	LCSW/ Trained in Infant Massage, Attachment Framework
6	LCSW/Attachment Framework, Ecosystemic Practice
7	LCSW/ Psychodynamic Child Therapy, Somatic and Body Psychotherapy
8	LCSW/ Trained in Child-Parent Psychotherapy, Psychodynamically and Somatically Oriented Therapy.
9	Provisionally Licensed Professional Counselor/ Trained in Attachment and Biobehavioral Catch-Up Model and Trauma-Focused CBT, and Cognitive Therapy.
10	MFT / Registered Drama therapist, Attachment Framework, Early Childhood Mental Health.
11	LCSW/ Attachment Framework, Family Systems, Trauma-Focused Therapy, Psychodynamic Framework.

The purpose of sampling clinicians working with mother-child dyads exposed to domestic violence was to determine whether these clinicians perceived the body as being a part of treatment with the specified population in dyadic therapy, and how/if they made use of body-oriented interventions in their clinical work with these clients. Participants were not required to work exclusively in a dyadic modality, nor exclusively with mothers and children exposed to domestic violence, but simply had to have had current or past cases involving mother-child dyads exposed to domestic violence, and to make use of dyadic therapy with mothers and young children as at least one of their chosen treatment modalities. In addition, as stated above, participants were required to be: English-speaking, in practice for five years or more, and

licensed or provisionally licensed. Because of the specific nature of the inclusion criteria, there were no exclusionary criteria for the sample in this study other than that a given candidate did not meet the inclusion criteria.

As there was a dearth of literature on this topic, I chose to conduct an exploratory/descriptive study in order to examine integrative clinical work that is currently being done, but that is not currently supported by academic research, for the most part. Past researchers have used qualitative interviews and quantitative attachment scales, and mixed methods in order to establish: the importance of attachment (Cassidy, 2008; Johnson & Lieberman, 2007), the role and importance of physiological and neurobiological processes in attachment formation and trauma (Ogden et al, 2006; Schore & Schore, 2007), the effects of trauma on attachment and the ability to regulate emotions (Perry et al., 1995; Schore & Schore, 2007), and the efficacy of programs addressing both trauma and attachment in dyadic therapy (Dozier et al., 2006 and 2008; Lieberman et al., 2005). The efficacy of body-based psychotherapy has largely been measured through descriptive case studies (Devereaux, 2008; Coulter & Loughlin, 1999; Ogden & Minton, 2000; Ogden et al., 2006; Tortora, 2010). Because there was a lack of empirical research on the integration of these theories and practices despite its presence in clinical practice, I chose to conduct a qualitative study based on interviews with clinicians in order to substantiate the necessity for further empirical research on the application of body-oriented work to attachment-based dyadic work with mothers and children exposed to domestic violence. I chose to conduct qualitative interviews in order to gain more nuanced and detailed responses.

For this study, a non-probability, convenience sample was used in order to obtain the information being explored. A snowball sampling strategy was used to gather initial participants. I initially spoke with people/clinicians with whom I was already acquainted who worked with

young children, domestic violence, and/or attachment issues. These people then provided names of other clinicians doing dyadic work with mothers and their young children. As potential participants were identified, I emailed a recruitment announcement describing my study and specific inclusion criteria. Once potential participants responded to the recruitment announcement and expressed interest in participating, I contacted them by phone or email to schedule an interview. Once interviews began, participants then referred me to other clinicians who fit inclusion criteria.

### **Data Collection**

Nine in-person and two phone interviews ranging from approximately 20-45 minutes in length were conducted in order to collect empirical data on how clinicians perceived the body and body-based interventions as being a part of their work with mother –child dyads exposed to domestic violence. Clinicians were asked seven open-ended questions in order to elicit their perspectives on the body in their clinical practice.

Once approval of my study and recruitment and interview protocol were obtained from the Smith College Human Subjects Review Committee (HSRC), I began the recruitment process. (A copy of the approval letter from the Smith College HSRC is contained in Appendix A, and a copy of the Recruitment Announcement sent to participants is contained in Appendix B.) Once potential participants responded and expressed interest, an interview was scheduled. The nine in-person interviews were conducted in the participants' psychotherapy offices, and the remaining two interviews were conducted over the phone. Participants were provided the Informed Consent Form at the beginning of the interview. (A copy of the Informed Consent document approved by the Smith College HSRC is offered in Appendix C.) The Informed Consent Form was sent by email to participants being interviewed over the phone and were then mailed back to me before

the interview. Interview questions were not sent to participants prior to the interview. (The Interview Guide used in the interview is contained in Appendix D.)

Interviews were recorded by digital recorder. Interview questions were asked in an almost identical manner in each individual interview. Additional questions were asked in some cases for clarification purposes. The order in which questions were asked remained the same throughout the entire study, and no questions were eliminated or added. I transcribed each interview myself, immediately after each interview was completed.

### **Data Analysis**

For the purpose of this exploratory study, data were analyzed using a general inductive coding and analysis strategy. Thomas (2006) stated, “The primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies” (p. 238).

Interviews were closely read numerous times until I was able to establish familiarity with the content of the interviews and to begin to identify and understand themes that occurred in participants’ interview responses. After this close reading, I began to define categories for coding. Coding was conducted manually. I identified three main categories, and then defined specific themes discussed in each category: 1) General Relevance and Importance of the Body in Treatment – “The Body is Relevant,” “The Body as a Way In,” “There’s No Escaping the Body,” “The Challenge,” and “The Potential Risk of Boundary Violation” 2) How The Body is Specifically Related to Treating Attachment Between Violence-Exposed Dyads – “Domestic Violence as a Bodily-Based Trauma,” “Co-Dysregulation of the Dyad,” and “Maternal Projections” 3) The Integration of the Body in Intervention Strategies – “Processing with Mom,”

“Noticing and Naming,” “Touch/Relearning Touch,” “Asking Permission,” “Attention to Basic Bodily Elements,” and “Specific Body-Oriented Interventions Employed.”

## **Chapter 4**

### **Findings**

This qualitative study explored how clinicians working with mother child dyads exposed to domestic violence perceived the body as being a part of treatment of the attachment relationship. In this chapter the findings will present the numerous and complex ways in which clinicians defined the relevance of the body in attachment-based treatment with mother-child dyads exposed to domestic violence, and the subsequent self-defined, body-based interventions the employ.

#### **General Relevance and Importance of the Body in Treatment**

##### **The Challenge Is...**

An important theme that emerged in interviews with participants was the idea that attention to the body was alive in participants' clinical practice with mother-child dyads exposed to domestic violence, but that they had previously not specifically identified it as such. Five participants explicitly expressed timidity in identifying themselves as working somatically (unless they were explicitly trained in somatic psychology) despite their extensive discussion of the body's role in trauma and attachment and their specific use of body-oriented interventions.

The following quotes captured this general sentiment:

OK, so the thing that's challenging is that we are just in the beginning stages of learning how to integrate elements of the body in our work with violence-exposed women and children. So I've gotten the sense that there is an acknowledgement in the field that the body is important and relevant, but we're just beginning to explore how to exactly work with body. I know that in my training in working with adults and the body and trauma, I've been eager to apply what we know about our work with adults to the work with the

attachment and with children, but I just feel like how to do that exactly is tricky.  
(Participant 2)

I mean, in talking about all of this, I guess I really do make a lot of use of the body. I know that I think the body is important. I know that I value taking in information from others who are somatically focused, like dance therapists, or sensorimotor-psychotherapy, and I know I am a consumer of research about trauma and the body, and attachment-based, bodily needs. But I'm realizing I just never really thought of myself as being one of those people, you know, I would have said, 'Yeah I'm psychodynamic, I'm family systems oriented, I'm trauma-focused,' but somehow wouldn't have thought to say I'm somatically or body focused. But it's just so funny though, because here I am talking about all the ways I appreciate the body and the ways I incorporate it into treatment.  
(Participant 11)

The body is so much a part of the work, but it's not necessarily common for there to be like this overarching intervention. I mean it's like, 'OK, I think I'll make use of infant massage now' but it's not like we say, 'We do body-oriented mother-child work.' To me the somatic work is crucial, but there is so little out there that addresses this topic specifically, that I feel like I'm sort of making it up as I go along. (Participant 8)

You know, it's funny, 'cause I think in dyadic work you can't avoid the body with little kids, but it's not necessarily named in that specific way. But there's no question for me that attachment and dyadic work inherently involve the body. It's so inherent it's hard to name really. I often think of somatic therapists as working with adults and teens, but really so much of dyadic work is somatically based; we just don't name it that.  
(Participant 3)

You know it's not like I say, 'OK, now we're going to do infant massage' or 'Now we're going to do a relaxation technique.' I'd say I apply the principles of my training in infant massage and what I know about the body and touch, but I'm not sure what to call it, or like how to specifically identify it. (Participant 5)

It's funny, like we all know we have a body. But we did this weird thing in psychoanalysis where we said, 'You don't have a body; you just have a voice, and the voice comes from this unembodied psyche, and we're safe because we've disembodied you, and we just talk from this other place.' I mean great people, like Winnicott, are almost talking about all of this, but without really talking about it. (Participant 1)

### **The Body is Relevant**

Eleven out of eleven participants interviewed stated that the body was "relevant," "integral," "crucial," "important," "essential," and "a given," in attachment-based, dyadic work. While it was a universal sentiment that that body was important in participants' clinical work,

there were varied descriptions, all with the same underlying core theme, of the body's relevance in treatment of mother child dyads exposed to domestic violence. The following quotes illustrate some of the specific ways participants generally defined the body's importance:

By understanding the body we can demystify what the behaviors mean, and bring it to a level where ultimately the therapist, the mother, and the child, can have greater compassion for what is going on, and therefore there's a greater likelihood that the problem will be more comprehensively dealt with, dealt with from the bottom up... . This work is about coming together emotionally, cognitively, and then through the body... . I understand and really truly believe that if the body is not being addressed, then the social and personality aspects can't be addressed. (Participant 2)

Everybody is comforted on some dimension by knowing they have a physical presence in the world that is acknowledged and seen, and reflected. We can just feel how we know ourselves because people respond to all dimensions of ourselves: our running-self, our jumping-self, our eating-self, our cuddly-self, our sleeping-self, our embodied-self. That's all to say, the body shows up in the room, and you either avoid it, which actually takes more work, or you work with it. (Participant 1)

I think that we store trauma and our memories in our bodies and so I think just talking about an issue intellectually usually does not accomplish getting it out on a somatic level. I think there has to be some kind of bodily release in order to really, on a cellular level, make that transformation and release that trauma memory. (Participant 8)

Five of eleven participants spoke specifically to the bodily underpinnings of attachment and regulation/dysregulation as being an important justification for attention to the body and physiology. The following two quotes are from participants who spoke ardently of the importance of recognizing the physiology behind disruptions in attachment and dysregulation:

It's crazy to me that attachment is not talked about more as a physiological experience of safety. An un-rocked baby who needs rocking, dissociates. That same baby rocked, feels inner harmony. So for me, a lot of attachment and disruptions of attachment are about met and unmet bodily experiences... . So to not think about the body in disruption of attachment is almost impossible. (Participant 1)

We know that one of the issues that comes up with exposure to domestic violence (and other trauma) has to do with the dysregulating experience. So a child between zero and two, after witnessing domestic violence, can display emotional manifestations of dysregulation, like being difficult to soothe and being more clingy. But, we can also think of those things as having a bodily core. Really, that difficulty in soothing when crying



may have hormonal, muscular underpinnings. And unless we have more of a vocabulary to help us articulate it, then we won't really know how to work with it. (Participant 2)

### **There's No Escaping the Body**

While every participant identified the body as relevant and important, there were four participants who went a step further. These participants each emphatically asserted that in fact there is “no avoiding” or “no escaping” the body in work with mother child dyads, and in mental health work in general. One participant stated, “I think about it as everybody, every body, has a body. Really, there is no psyche without a body” (Participant1). Other participants with this perspective asserted:

I definitely see the body as being an integral part of treatment. I think it's not just relevant, I think it's *integral* to treating issues around attachment and trauma. (Participant 10)

It's hard to separate the body out from the work once you start to think of it that way. It's hard to even know where to begin; to separate the two is pretty impossible actually. You have two nervous systems interacting; you have all the sensory nervous system with touch and sound and sight and interaction. Where do you even begin to exclude the body? (Participant 7)

I think when working with such young children, like three and under, there's no escaping the body when working with the parent child dyad. I think about the connection in mind *and* body. I think just 'cause of the nature of how you care for infants and toddlers touch and interaction comes into play. And when there's a trauma for the dyad, I really start to think about how the body and attachment changes. Meaning, does the dyad become more attached and symbiotic, or separate? And children, before they learn how to manage their feelings, they inevitably express their feelings through their bodies, and really the same can be true for so many adults. So I really do think it's important to think of it as tied together, inseparable actually. (Participant 3)

### **The Body as a Way In**

Four participants identified the body as being an important early site for intervention in the treatment of mother child dyads exposed to domestic violence. One participant stated, “Physical expression can actually be the place where a mother and child reenter into their

connection” (Participant 4). Other participants discussed working with the body and physical interaction as being necessary for grounding the two dysregulated members of the dyads, while also promoting the attachment between the two. One therapist illustrated this point by saying “When those core co-regulatory and self-regulatory processes aren’t online, then the body is our way in.” (Participant 1)

Expanding on the theme of the body as being a way into working with a dysregulated dyad, some participants spoke specifically about the body as an entry point into grounding the dysregulated individuals and simultaneously strengthening the attachment relationship. One participant stated, “I think the first step is, or can be, or maybe even has to be, getting connected to the body. I mean like so basic, like saying ‘Where are we in space? Where are our feet and where are our hands?’”(Participant 8). Other participants spoke even more extensively to this theme:

Think about like physiologically how bodies are and what happens to them when they’re out of whack and then bringing them to a place of calmness. Or folks that have experienced trauma and dissociate, it’s all about getting them more grounded in their bodies, and that can certainly happen for children as well. So when you have a dyad that’s been traumatized and you’re a dyadic therapist, sometimes you’re doing both simultaneously, you know holding both mom and child’s hand and saying ‘OK, where are we right now, where are our bodies right now?’ (Participant 3)

So in doing body-oriented dyadic work we can begin to address some of the things that can be helpful for Mom at a physical level and that can then also be helpful for her child at a physical level. And that even in the dyadic work, Mom’s own ability to reach a higher level of a physical ground is going to provide for her young child a calmer body to crawl into, and to be held into, and that in and of itself is going to have a soothing, grounding impact for the child’s body. And that with repeated experiences of calmer soothing, physical soothing, then the child may relearn a different experience in the body so that he or she can become less impulsive, less aggressive, less whatever the symptom may be. (Participant 2)

## **The Body as Specifically Related to Treatment of Violence Exposed Dyads**

### **Domestic Violence as a Body-Based Trauma**

Four participants explicitly expressed understanding the body as being relevant in treating mother-child dyads exposed to domestic violence precisely because they understood the body as being the site of the trauma in the context of domestic violence. The following quotes illustrate this sentiment among participants:

Domestic violence is a particularly painful type of traumatic event because it breaks up expectations of what a loving relationship is supposed to be about. ... It's something that's of a very relational and personal nature, and where the body has been the site of the trauma. And so, for that very reason, physicality, touch, and physical behaviors, become very relevant. (Participant 2)

So domestic violence is a violation of the body, and typically a physical violation of the body. But it's also a threat against the body's sense of safety. So it's basically a trauma to the body, both physical and emotional. So one of the biggest traumas in domestic violence is that the person victimized has their sense of safety and capacity to protect themselves and their offspring overwhelmed. So there's a chance through the body to re-experience the body. Through resourcing, one can experience what the body didn't have: to push back, to stand up, to not cower, all really important experiences for the body to have. (Participant 1)

Usually domestic violence involves some type of physical abuse, so we're looking for any type of clinical impact of that trauma and how it's interpreted through the body. So if you've been abused or witnessed the abuse of your caregiver there are all kinds of manifestations in terms of somatic and affective issues that are related to the physical trauma, and as the trauma relates to the concept of the body and expressions of intimacy and love and attachment. (Participant 6)

### **Co-Dysregulation of the Dyad After Domestic Violence Exposure**

Five participants talked about attachment disruptions in mother-child dyads exposed to domestic violence as being related to the interaction of two "dysregulated," "agitated" nervous systems. Of those five participants, three spoke directly to the importance of understanding and attending to the simultaneous dysregulation of both mother's and child's systems after trauma, and how it may fuel disruptions in attachment:

Co-regulation and self-regulation and dysregulation are all bodily processes and I think there's something that happens when there's domestic violence when a parent is over-agitated or overexcited, or hyperaroused, or hyper-vigilant, where they misread the cues of the child, and so that child gets an overreaction to whatever they're doing, and then the child's emotional state or enactment or expression is then dysregulated. (Participant 1)

Dysregulation of the body is such a big piece of trauma, of witnessing and being the direct victim of domestic violence, and you know regulation of the body is just such an important piece of good mental health and functioning. And there are big issues with my moms and kids, especially with exposure to domestic violence, about the moms not being able to co-regulate with their kids. And the kids are so dysregulated because of numerous high risk factors in the home, violence being one of them. So developing soothing strategies with parents, and also helping them to learn to recognize when the kids are dysregulated, is a big part. (Participant 10)

I mean I think when I'm working with especially really little ones, who were in domestic violence in the totally pre-verbal phase, the memories of the events really present as dysregulation of physical states like eating, sleeping, and crying. I saw one baby who would like cry and cry all night long. And you know there's nothing you can really do except to simply hold and rock that baby in order to calm their system down, regulate the nervous system. And so if Mom can calm *herself* and she's able to withstand that crying, and therefore calm *both* their systems, then that's great. But, it can also happen like it did with this one baby I'm thinking of, where *Mom's* nervous system is *also* so agitated and overwhelmed, and so, then baby cries and cries, and Mom just wants him to go to sleep so her anxiety level rises, therefore causing baby's anxiety to increase, and instead of any co-regulated resolution you have this cycle of them agitating one another. You know, babies are not a separate being yet, and are still so connected to their mothers, both through the psyche and biologically. So where Mom's dysregulated, baby becomes dysregulated. (Participant 8)

### **Projections/ Distortions**

Five participants spoke of the impact of maternal projections onto the child that result directly from exposure to domestic violence. While maternal projection in itself was not spoken of in direct relation to the body, participants identified maternal projections as influencing the way mothers were able to attune to and read the cues of their children. Maternal projections were seen in some instances to be connected to mothers' own dysregulated, overwhelmed nervous systems resulting from being the victims of domestic violence. Additionally, these participants asserted that mothers' negative projections onto their children resulted in the mothers pulling

away from their children and being less open to nurturing through touch and physical contact. Thus, it was generally felt that negative projections onto the child or distortions of the child's intentions or behavior related to the furthering of the child's dysregulation as a result of the witnessing of domestic violence.

When a young mother who's been a victim of domestic violence comes in with her child, she may see her child's aggressive behavior as intentional, as a way to defy her, or she may project onto the child [or distort] that he is just like the father. If a mom is watching her child's behavior and it's anything like the person who battered her then it becomes particularly poignant to help Mom understand what the behavior is really about. Because Mom's interpretations could potentially create a distance between her and her child. If Mom really starts to believe the child is just like the violent partner, she may become distanced and therefore become less likely to initiate or even want that essential physical contact with that child. (Participant 2)

I have a client who is the parent of two little ones, and during her second pregnancy she became the victim of domestic violence. And everything stems from her triggered trauma responses to the kids awkwardness and rowdiness; you know she has a sort of startle response with the kids' movements. And so educating Mom about body, mind, affect, dysregulation, is really helpful and paramount, because Mom, due to her own hyper-vigilance, can take some of the kids' responses as aggressive rather than being about dysregulation and also being age appropriate. (Participant 6)

There are really a lot of projections that moms put onto their kids, especially their boys, after domestic violence. You know it's that projective identification. It's like, 'Oh he's so aggressive,' when really he's just hungry. (Participant 10)

You can have parents that are very scared of their kid, or who look at their kid and see the person who hurt them. So I feel like the work looks different depending on the age of the kid, but the work is partly about adults learning to be the bigger, calmer, stronger, wiser person in their child's life. (Participant 3)

## **The Integration of the Body in Intervention/Assessment Strategies**

### **Processing with Mom**

All participants identified the attachment relationship between the dyad of caregiver and child as the focus of treatment: however, all eleven participants also spoke about engaging in individual work with Mom in some way or another. While participants reported a variety of ways of working with Mom, all described processing with Mom, in some manner, her own bodily experience of the trauma. Participants described this as being an important part of addressing the co-dysregulation discussed in the previous section. Participants discussed specific body-oriented processing with the mother in the following ways:

I feel like there's such a disconnect from the body for these moms because of their history. So it feels really important to bring that piece in. I really work with moms on how to be present in their bodies so then they can connect with their kids. It's about releasing that trauma they hold and understanding their own feelings and triggers. (Participant 10)

If Mom can understand how the trauma has impacted her own body, then she can recognize that her child isn't displaying aggressive or impulsive, or whatever kind of behavior because he's a terrible child, or he's just like his father, or he's trying to defy Mom, or get attention, but rather that there is a physical element that she may be able to recognize in her own body, that also needs to be addressed for her child as well. (Participant 2)

Individually with Mom I do more specific somatic work with mom. Like I'll help Mom access and process her trauma in her body. Basically I have her track her body sensations and which memories are coming up as she stays with those certain body sensations. We continue to explore these things and check-in with the body; otherwise, you could potentially spend the whole session just kind of managing these two dysregulated individuals influencing one another. (Participant 8)

### **Noticing and Naming**

Six participants spoke of using “noticing” and “naming” as an important intervention in work with traumatized dyads. Participants spoke of “noticing” or “naming” as a way of “calling Mom’s attention” to the interaction between Mom and child or Mom and/or child’s individual

emotional/bodily experience. Some participants spoke of “noticing” as a way to introduce psychoeducation for Mom in a non-threatening way, while others spoke of simply encouraging Moms themselves “to notice” their baby’s and their own experience while interacting. The following quotes illustrate how participants discussed the ways they used “noticing” and “naming” with mother-child dyads.

I start with a very simple psychoeducation about the body with moms. I start with mom and say, ‘So have you noticed that since this experience you startle more easily when you hear a loud sound? Do you jump more than you used to?’ And that can be a way to have mom in her own body relate to and notice how the body is relevant here for her child. (Participant 2)

It’s really about awareness and attunement. You know not just saying ‘OK, now touch them this way or that way’, but really ‘Notice, notice yourself, and your child’s behavior, and what it’s saying.’ (Participant 5)

When I’m working with mothers who have been traumatized and victimized, I try not to ‘do.’ I try to be present and curious. So I’d say, ‘I notice when you pick his leg up and he kicks, you startle. Wow. And I notice when his hand reaches out to you, and your fingers are together, you really slow down, and his gaze is now available to you.’ So it’s letting the body speak and being the voice of the body, so that we develop a shared, investigative, curious mind together. So it’s not me saying ‘OK, do x, y, and z’ even though I know x, y, and z might be helpful. I’m really looking for when x, y, and z might be happening organically and when it happens, I notice and name it. (Participant 1)

A lot of times, I feel like I’m helping the parent be curious about the child, you know watching, wondering, noticing, observing. I mean that’s what I do when I’m working with a child individually. So when I’m working with the two together I might say about the child ‘Oh, wow, I’m noticing your movements are getting very big right now. You’re arms are opening very wide and moving very fast.’ And meanwhile, I’m positioned near Mom, making occasional eye contact, inviting her into noticing and watching with me. (Participant 11)

I think touching and other nurturing moments between mother and child happen spontaneously and it’s funny because it requires very little intervention from me, besides just saying, ‘Wow, you guys are so connected right now.’ I’m just like naming and talking about those moments with the mom and child when they happen. There’s something about being the observer of their relationship like when they’re cuddling, or if Mom is able to calm the kid after they fall down. You know just noticing and highlighting for Mom. (Participant 8)

We find those things taking place in the dyads in real time and we use them as teaching moments in the dyadic interaction to experiment with different ways of handling and noticing the impact of certain kinds of interaction. So we don't do it in a critical manner, but we notice and then call the parent's attention to the baby's reaction and physiological response to the interaction between them. (Participant 7)

### **Touch/Relearning Touch After Domestic Violence**

The various elements and importance of touch and physical contact in the mother-child dyad was a major point of discussion within interviews. Participants spoke about touch and physical contact in response to specific interview questions targeting this aspect of attachment and treatment; however, this theme was referenced continuously throughout answers to all interview questions. Some clinicians saw working with the body in treatment with mother-child dyads as inextricably linked to touch and physical contact, due to the young age of the children being treated. While all eleven participants interviewed understood touch as an essential part of healthy development, bodily regulation, and the building of healthy attachment, six participants spoke about an added importance of a focus on touch and physical contact when working with violence exposed women and children. These participants discussed there being a "relearning," "re-organizing," "re-calibrating," or "re-training" of touch between dyads exposed to domestic violence.

I feel like every human is born with the need for touch, and research backs this up. A child develops confidence, trust, and security, from the touch of a caregiver. And that's one of the reasons why we think it's so essential when focusing on building attachments and security, is to have the child really begin to get comfortable with the physical connection, because it is so key to developing that healthy, necessary attachment. You know, oftentimes the child observed physical interaction as being violent, and scary, and as a bad thing. So if we can incorporate it in the intervention, we can show there are other ways of touching, that physical interaction doesn't have to be a bad experience. (Participant 9)

Domestic violence is a physical trauma in the home, with supposedly loving partners, and how they're treating each other is often directly mirrored or imitated by the kids. So you



often have to retrain the kids and the parents together in using loving touch, and demonstrating overall loving interactions. (Participant 5)

I think working with the body and touch is really important in working with domestic violence exposure because it gives a different experience for the mom and the kids about touch, and physical contact, and body experiences. (Participant 10)

Physical contact really communicates much more than words do. Every time the mother touches the child in a soothing way, that's creating that neural pathway that's helping baby to learn to self-soothe over time. And I think certainly with domestic violence, touch has been something scary. And so in that case you have to recreate those pathways and you have to do this whole retraining through repeated physical interactions that are safe and nurturing, and different from that scary kind of touch. The type of soothing that comes from that type of interaction, you know it makes mom and child feel better, feel calmed, and it's an intimacy that's different from the violence for the both of them. (Participant 8)

Especially with young kids, touch is how they get to know the world. So in many ways, you have to retrain their brain to trust touch and know how to use it. (Participant 3)

As a result of domestic violence, Mom may become more aversive to touch; she may not be able to accept affection from her child, and in fact it may bother her. Also, I can say, 'OK, Mom hold your child now', but it doesn't mean much if Mom doesn't understand how unsettling violence and trauma is and how healing touch and physical contact can be in the face of it. It may be something that needs to be recalibrated or relearned after trauma. (Participant 2)

While being trained in infant massage and maintaining a strong belief in the importance of touch in attachment and dyadic treatment, one participant expressed a cautionary statement about a focus on touch in dyadic attachment-based treatment:

I work from a dynamic living systems model. It's a non-hierarchical model, so touch is not more important than speaking, hearing, seeing, responding, keeping baby in mind, mental and emotional attunement, handling, watching and wondering about baby, orienting towards baby. If you just limit, or over-focus on touch as some kind of panacea, outside of the range of what you can really do, and you think it's doing everything, well, you're missing the point. Infant-parent mental health is inherently interdisciplinary and you have to work that way. You know, it's about not focusing on one thing. (Participant 7)

## **Asking Permission**

Another common theme in participants' responses within interviews was the idea of "asking permission" for touch. Six participants spoke to this theme. Participants generally spoke about asking permission for touch in the context of encouraging parents to respect their child's body and boundaries. These participants saw this as an important aspect of working with the bodies of the mother-child dyad. This theme of "asking permission" stemmed, for certain participants, from training in and use of infant massage. However, others spoke of this as something they employed as a general tool of honoring boundaries, without the direct influence of infant massage.

It's all about giving someone total authority over their body. So, in massage, it's inviting and asking the baby permission to touch and respecting when baby gives an indication that it doesn't want to be touched. (Participant 1)

I always make sure that we ask permission to touch, really respecting everyone's boundaries. (Participant 10)

I talk with Mom about asking the child for permission to touch them so that the child really early on gets the idea that they have power over their bodies and that Mom gets that idea too. (Participant 8)

We teach mothers to attune, to not objectify the baby, to ask for permission to touch, even from a newborn. We work with them on preparing themselves in a ritualistic way through asking for touch from the child or baby, and then children start giving permission in new ways. (Participant 7)

In the room with the two, I have asked children permission for their mothers to put their hands on the part of the body where they are feeling whatever emotion, whether it's a hurting in the heart or a buzzing in the head. (Participant 4)

## **Basic Bodily Elements**

In discussion of treating attachment and the bodily dysregulation of violence-exposed mothers and children, participants frequently referenced "basic" bodily elements. Five participants referred to eating, sleeping, toileting, basic sensory experiences, and bodily mastery

as being the areas that are often dysregulated in young children after trauma, as well as being integral elements of the attachment relationship. These participants felt that attention to these basic bodily elements was essential to comprehensively treating mother-child dyads.

I think a lot about addressing basic physical needs. Like I always have water available, or making room for kids to be able to use the bathroom. Really, just addressing those basic bodily needs is important. All the bodily functions are very important, specifically with children. (Participant 4)

I mean, a big part of young children is regulation and dysregulation. Those are very bodily-based in themselves. But it also translates then to eating, sleeping, using the toilet, all those can become issues in dysregulation after trauma. The body is just the site for all the symptoms manifesting. (Participant 5)

For kids it's actually more important to go into the normal experience of being a child like eating, cooking, playdough, sleeping, all of that. Instead of trying to dissect them and the trauma, it's about getting them back on track. It's about normalizing, enriching, and resourcing, and positive experiences of the self and the body and mastery. (Participant 1)

I work with Mom on basic things like bathing and feeding, and helping her to make those simple moments positive interaction moments. In my work I see a lot of trauma that's manifested in the basic bodily regulation or dysregulation. It's about looking for how to do restorative work with those body-based issues. (Participant 6)

The attachment relationship is so connected to those everyday things like changing diapers, and sleeping together and feeding, so it becomes really important to address and attend to those things as a dyadic therapist. (Participant 3)

### **The Potential Risk of Boundary Violation**

Rather than identifying any specific downfall or problem with incorporating the body in treatment, all participants largely provided a cautionary statement that it is essential to “be aware of,” “take caution with,” “pay attention to,” and “follow” the client’s process so that the therapist does not “override” the client. Subsequently, ten out of eleven participants referred to “boundaries,” or the violation of boundaries, as the primary potential downfall of working with the body in treatment. Some participants discussed boundaries in relation to the therapist’s

interaction and work with the mother and child, while others referred to the potential violation of boundaries within the dyad.

The potential big risk with including the body, and it's why therapists avoid it, is that you override somebody else's body. You can't have authority over someone else's body. It doesn't matter how much education you have, or how many interventions you've developed. With trauma, it can be really damaging to take over authority, or override, because if I take over without you wanting or inviting it, then I've traumatized you again. And specifically domestic violence is all about controlling another person. So that's the last thing you would want to do as a somatically oriented therapist. (Participant 1)

I think in general it's tricky and you really have to follow the lead of your clients in recognizing what they are ready for and not further violating boundaries. (Participant 10)

I would say it's important to talk with parents about respecting boundaries. Boundaries are important, but I don't know that it's a downfall in body-oriented work. I mean it's an added benefit to make stuff that clear and give people power over their bodies. (Participant 8)

Well you know the body protects itself during and after trauma and walls itself off. We have to honor the way the body protects itself. You can't run ahead, you're trying to stay with that process, and honor their willingness to enter or not enter, because that's theirs. (Participant 4)

In order for us to be licensed we have to be mindful of boundaries, physical boundaries, emotional boundaries. It's a struggle. I think for clinicians who do not work with the body, it's clearer and easier, it's a non-issue. It takes more attention and care when you're working with body, in order to maintain boundaries. (Participant 2)

### **Specific Body-Oriented Interventions Employed By Participants**

All eleven participants identified using some form(s) of specifically body-based intervention(s). Participants were asked to identify the interventions they used that were specifically body-based; all interventions listed were defined by participants themselves as body-based. All eleven participants identified observation of the individual bodies/physical interactions of the dyad during assessment/treatment as a specific body-based intervention. In addition, all eleven participants identified psychoeducation about the body, bodily dysregulation, and trauma as a body-oriented intervention they employed. The following quotes highlight some

of participants' descriptions of the body-based interventions and assessment techniques. A table including all participants' employed body-based interventions follows these quotes.

When I'm working with a parent and child, I first observe the distance they keep and how much they touch each other, and what kind of touch it is. So I think what I'm looking at is the gentleness and nurturance of a mother's touch. Also the use that the child makes of the mother's body, like leaning in, climbing in, whispering in the ear, even how much hitting and aggressive interaction there is. So I really make a lot of use of observation of the body and body language. (Participant 4)

I do a butterfly hug, which is an EMDR technique, which is really a bi-lateral tapping. I'll teach the parent and child together, but they're also doing it individually. I may have the parent tapping the child, but it's almost like they're hugging the child. It's not just about tapping and bi-lateral stimulation; it's more about a hug and being present. (Participant 4)

I've used like a kind of music, dance therapy, which has really been based in some of the formulative, developmental sensory-stimulation things that are so important to do with young children. I have parents do everything from playing patty-cake to the wheels on the bus, to dancing together, all to promote healthy interaction. I also use quite a bit of relational techniques with both parent and child together. (Participant 6)

In assessment I look at how Mom is sitting. Is she in the chair or on the floor with child? Is her body pointed towards the child? Does she physically cross into the child's play with her hands and body? Does she move toward the child? All of that is important in assessment. (Participant 6)

In the model that I implement now, the Attachment and Biobehavioral Catch-Up Model, part of it is having mother and child make bodily contact, because of the importance of touch in attachment. So sometimes we'll give the mother and child lotion and stickers to incorporate into treatment. So the activities involve the child putting the lotion on the mother's face or hands... . We have the child rotate the lotion on their own hands and then on Mom's hands. And then we have Mom do it with the child as well. And then with stickers, Mom and child put the stickers on each other's face and arms and hands, so they can have that playful, nurturing experience that incorporates touch and physical interaction. Also, we do a lot of lap games like This Little Piggy and Patty-Cake. (Participant 9)

I like to make everything in the room come alive, all the art materials, all the puppets, the cars, etc. So similarly, I like to encourage the body to become alive. So I have kids show me and their parents, and I'll have parents do it as well, how they feel through movement or sound, or pointing somewhere in the body. I also engage both the parent's and the child's bodies in relaxation and breathing, and grounding, particularly after traumatic material has come up. I think I also focus a lot on psychoeducation with parents, like just really helping Mom to understand what's normal and healthy, so that natural, normal bodily expressions are not denied or shutdown or shamed. (Participant 11)

A lot of work we do with moms and babies, which uses infant massage as a platform for supporting psychological and social/emotional development as well as attachment, targets both the mom's and the baby's autonomic nervous systems and baby's growing mind and brain. So we use massage, we use mindfulness-based techniques, we use breathing to help Mom understand the impact of her arousal level on the child, we instruct and use parenting education and psychoeducational interventions to help mothers understand the impact of their touch and handling of the baby. (Participant 7)

I do a lot of using the body to express feelings, so instead of talking, we use movement, or sound to express a feeling. I do a lot of mirroring one another and follow-the-leader. What else? We do swinging in blankets, parachute play. Also wrapping the kids up in blankets. I also do swaddling with moms and infants. So with babies, I often bring a sling for mom to use. (Participant 10)

Table 2

Participants' Training/Clinical Orientation and Body-Based Interventions Used

PARTICIPANT	TRAINING DISCIPLINE/ CLINICAL ORIENTATION	SPECIFIC BODY-BASED INTERVENTIONS USED
1	MFT/ Somatic and Drama Therapy, Trained in Sensorimotor Psychotherapy and Infant Massage	Psychoeducation about touch, and trauma and bodily dysregulation. Infant massage, Observation of and calling attention to bodily states and interaction between dyad.
2	PhD, Clinical Psychologist/ Infant Mental Health, Attachment Framework, Family Systems, Child Exposure to Violence, Trained in Sensorimotor Psychotherapy and Child-Parent Psychotherapy	Psychoeducation (trauma and bodily dysregulation, child development). Mindfulness and meditation. Observing, tracking and naming of bodily states, body language, movements, and interaction between dyad.
3	LCSW/ Early Childhood Mental Health, Attachment Framework	Psychoeducation about bodily dysregulation. Observing physical interaction. Tracking body sensations. Mindfulness and breathing exercises. Naming and processing of body language and gestures as well as physical interaction. Encouragement of touch between dyad using lap games.
4	LCSW/Child Play Therapy, EMDR, Psychoanalytic Training in Relational Models and Self Psychology, Child Exposure to Domestic Violence	Psychoeducation about trauma and bodily dysregulation. EMDR techniques of bi-lateral tapping used between dyad. Observing and naming of movements, body language, and physical interaction encouragement of touch between dyad. Locating feelings in the body. Movement exercises (mirroring activities and playing catch).
5	LCSW/ Trained in Infant Massage, Attachment Framework	Psychoeducation about trauma and bodily dysregulation. Calling attention to bodily states. Observation of interaction. Infant massage.
6	LCSW/Attachment Framework, Ecosystemic Practice	Psychoeducation about child development, trauma and bodily dysregulation. Observation of body language, movements, states, and physical interaction. Lap games such as Wheels on the Bus and Patty Cake. Movement with dance and music. Locating feelings in the body.
7	LCSW/ Psychodynamic Child Therapy, Somatic and Body Psychotherapy	Psychoeducation about touch and trauma and dysregulation. Observation and naming of bodily states and physical interaction between dyad. Mindfulness-based techniques. Breathing exercises. Infant massage.
8	LCSW/ Trained in Child-Parent Psychotherapy, Psychodynamically and Somatically oriented.	Psychoeducation about importance of touch and trauma and dysregulation. Observing and naming bodily states, body language, and physical interaction between dyad. Infant massage techniques. Mindfulness. Meditation. Breathing Exercises. Tracking body sensations. Sensory-oriented play such as playdoh and finger paint.
9	Provisionally Licensed Professional Counselor/ Trained in Attachment and Biobehavioral Catch-Up Model and Trauma-Focused CBT, and Cognitive therapy.	Psychoeducation about the importance of touch and physical interaction and attachment. Observation of physical interaction. Encouragement of touch and physical interaction between dyad through the use of play with stickers, and lotion. Lap games such as This Little Piggy and Patty Cake.
10	MFT / Registered Drama therapist, Attachment Framework, Early Childhood Mental Health.	Psychoeducation about importance of touch and bodily dysregulation. Observation of bodily states and dyadic interaction. Mirroring exercises, Follow-the-Leader, and parachute play. Using sound or movement to express a feeling. Breathing, relaxation, and mindfulness. Swaddling of young babies. Swinging in blankets.
11	LCSW/ Attachment Framework, Family Systems, Trauma-Focused therapy, Psychodynamic framework.	Psychoeducation about child development, bodily dysregulation and trauma. Observation and processing of bodily states, and physical interaction between dyad. Breathing, relaxation, and mindfulness exercises. Use of movement and sound to express feelings. Locating feelings in the body.

## **CHAPTER 5**

### **Discussion**

The purpose of this exploratory, descriptive study was to examine if and how clinicians working mother-child (0-5) dyads exposed to domestic violence perceived the body as being a part of treatment. The question in the study then involved: if they perceived the body as being a part of treatment, did they then make use of specific body based interventions and how were those interventions defined?

### **Major Findings**

The results indicate that therapists from a variety of clinical orientations and training disciplines perceive the body as being an integral part of treatment with mother-child dyads exposed to domestic violence, and do in fact make use of interventions which they identify as being body-based, whether or not they identify themselves as somatically/body-focused clinicians. A major finding was that many participants found the body to be relevant in treatment with violence exposed mother-child dyads precisely because they saw the body as the site of the trauma of domestic violence. Additionally, it was a major finding that all clinicians interviewed understood the body as intertwined with, and inherent in, the attachment process.

Participants' interview responses reflected a fundamental understanding of the body's relevance in attachment, trauma (specifically domestic violence), and mental health treatment. Clinicians who had training in somatic psychology and/or sensorimotor psychotherapy, spoke directly about the relevance of neurobiology and physiology. However, even those clinicians



who had a more limited vocabulary around neurobiology and physiology spoke extensively and in multiple ways about emotional dysregulation in both mother and young child as having a bodily core of physical dysregulation. As a major focus of dyadic therapy with children ages 0-5 is the treatment of disruptions in attachment, interviews reflected not only participants' purposeful focus on and appreciation of the attachment relationship between mother and child, but also the fact that they understood attachment as being a bodily process in itself, as well as essential to the development of the ability to regulate internal bodily and emotional states.

While the aspect of "touch" in therapy with the dyad was simply one part of the interview questions, some clinicians focused on touch and physical interaction as the primary way they perceived the body as relevant. It seemed that those who had less specific training in mind-body mental health treatment (such as somatic psychology and sensorimotor psychotherapy) spoke more about tangible elements, such as touch, physical interaction, and specific body-based interventions like lotion-play, lap games, movement exercises, and deep breathing. Those who had had more specific clinical training in body-oriented treatment discussed the relevance of the body more in terms of the body being an omnipresent, inevitable foundation of treatment.

One of the areas that was strikingly uniform in responses from participants across all training disciplines/clinical orientations, was the description of participants' observation of dyads in assessment, and how attention to body language and physical interaction between the members of a caregiver-child dyad was an assumed part of assessment, and ultimately treatment.

For all participants, there seemed to be an intuitive sense of the importance of the body in attachment, trauma and exposure to domestic violence. I observed that during interviews, when asked if they found the body relevant in the treatment of mother-child-dyads exposed to domestic violence, participants often cocked their heads to the side, and stated something like, "Well,

*yeah,*” with a tone that implied I had asked a question so obvious it was silly. While this basic assumption of the importance of the body was universal among interviewed participants, the ways in which participants went on to discuss the relevance and use of the body in treatment of violence-exposed dyads showed greater variation.

One of the most salient themes was participants’ discussion of timidity in identifying themselves as body-focused, despite their use and appreciation of the body in treatment. The theme permeated in words as well as hesitant, questioning tones, that yes, clinicians are making significant use of the body in treatment, but yet they don’t quite know what to call it or how to define it. Even those clinicians interviewed who had explicit training related to the body (in somatic psychology, infant massage, sensorimotor psychotherapy etc.) felt that it was a new and challenging endeavor to truly combine their training in trauma and the body as it related to adult individuals, with the work they were doing with traumatized mother child dyads. Those who had specific training and interest in explicitly body-based work seemed to have a broader vocabulary and were more comfortable in discussing the body as it related to the attachment between mother and child and the trauma of exposure to violence. Those with no official training with the body, were more likely to have difficulty in articulating the bodily experience of trauma, but were able to speak more directly to the specific interventions they used which they believed were connected to the body. Those with training in models such as sensorimotor psychotherapy and somatic psychology had difficulty speaking about “explicit” body-based interventions, because to them, the body was present in *everything*; they could not talk about the body as some separate, specific element. To these participants, the body was present in every word, every interaction, and every intervention.

As participants discussed specific body-based interventions, it seemed that for many, prior to the interview, they had not particularly identified their interventions as body-based. However, once asked to specifically identify the body's presence in their intervention strategies, participants realized that in fact many of the interventions they employed were body-based.

### **Limitations**

Limitations to the transferability and generalizability of findings generated by this study include a limited sample size and a snowball sampling method. As participants who expressed interest in participation were all made aware of the exploration of the integration of the body in dyadic work after reading the recruitment announcement, it is possible that it was those who already had an interest in the body who agreed to participate (even if they did not identify themselves as explicitly body-focused clinicians), thus possibly leading to 100% of participants identifying the body as relevant and important to work with violence-exposed mother-child dyads. This virtually universal endorsement of the importance of the body in work with this population would not likely be found in a larger sample of clinicians.

The specific focus on domestic violence may also be a limitation of this study. While domestic violence was often one of the primary presenting issues in participants' cases, there exists a vast array of other issues contributing to disruptions in attachment. Incarceration, poverty, substance abuse, caregivers' own trauma history and attachment style, and other co-occurring forms of abuse (sexual abuse, neglect, physical abuse etc.) all contribute to the nature of the attachment relationship between mother and child. Thus, the specific focus on domestic violence creates a potential over-simplification of the issues explored.

## **Research Implications**

This project aimed to explore the ways clinicians made use of the body in treatment of mother-child dyads exposed to domestic violence in order to highlight the increasing presence and importance of the body in everyday clinical work, even if it is not explicitly stated as such. In light of the ever-growing research on the role of neurobiology and physiology in trauma and attachment, the themes that emerged in this research project further support the everyday clinical practice manifestations and implication of these advances in knowledge and research. The study also illuminated the disconnect that many clinicians feel in terms of identifying themselves as body-oriented, even if their narrative descriptions precisely illustrate such an orientation. Further research with a larger sample size would be useful in further exploring the themes that emerged in this project, as well as in determining whether the findings of this study can be generalized. It would also be beneficial to conduct this study with two participant groups instead of one; one being comprised of clinicians with clinical training in somatics or the body, and one with no specific body-based clinical training. This would help to further explore the issues of what contributes to timidity and hesitance in identifying oneself as a body-oriented dyadic therapist. Perhaps the most important research implication of this project is the validation of the need for further research on the presence and efficacy of body-based dyadic psychotherapy.

## **Social Work Implications**

This project provided evidence of not only the growing presence of the body in clinical practice with mother-child dyads exposed to domestic violence, but also the vast array of possibility for multi-disciplinary, integrative approaches to comprehensive treatment. Ultimately, if clinicians are able to identify the ways in which they pay attention to the body in treatment with violence-exposed mother-child dyads, and to appreciate themselves as bodily-focused, their

work will likely become more purposefully integrative, while also reflecting current and significant advancements in research. Perhaps most importantly, integrative treatment that reflects and honors the complexity of human body, mind, emotion, and experience, will guide us as clinical social workers in finding increasingly innovative and effective ways to walk with our clients on their journey of healing.

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**Appendix A:**  
**Human Subjects Review Committee Approval for Study**



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School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

January 6, 2012

Danielle Sachs

Dear Danielle,

I appreciate your effort to meet our requirements. You have done a very nice job and offered very professional and clear responses. I think your study is very interesting and wish you the best of luck in completing it!

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a horizontal line underneath.

David L. Burton, MSW, PhD  
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

**Appendix B:**  
**Recruitment Announcement**



**Are you a clinician who has current or previous experience working with mothers and children (ages 0-5) exposed to intimate partner violence?**

If so, please consider participating in my study. I am Danielle Sachs, a graduate student at Smith College School for Social Work, and I am interested in interviewing you about your views concerning benefits, risks, and challenges of integrating body-based interventions in dyadic clinical work with those who have been exposed to intimate partner violence. While my primary goal is for you to define how and if you see the body as being a part of treatment and the subsequent interventions you use, examples of body-based interventions include but are by no means limited to: the use of touch and physical contact between mother and child, observation and processing of body language and/or gestures, the use of movement (such as dance), infant massage, EMDR, and mindfulness, relaxation, and desensitization techniques.

If you are an English speaking, licensed or provisionally licensed mental health professional, in practice for at least 5 years, and have worked with mother-child dyads exposed to intimate partner violence, I would like to include your views in my research. I am especially eager to talk with clinicians from varied disciplines, racial/ethnic backgrounds, and whose demographics are diverse in other ways.

If you volunteer, you will take part in a 30-minute to one-hour interview, in which you will discuss your perspectives on the use of the body and touch in treating the relationship between mother and children (ages 0-5) who have experienced violence in the home. Your confidential interview be recorded, transcribed, and compared with those of similar clinicians as part of my thesis research project.

If you are interested or would like further information, please contact me by cell phone or by email

**Appendix C:**  
**Informed Consent**

## Informed Consent Form

Dear Participant,

My name is Danielle Sachs and I am a graduate student at the Smith College School for Social Work. I am conducting a research study on the use of body-based interventions in the clinical treatment of mother-child dyads exposed to intimate partner violence, specifically those interventions that involve touch as a treatment modality. This research study will be used for the basis of my Master's Thesis. I hope that you will consider taking part in my research.

In order to participate in this study you must be a licensed or provisionally licensed clinician (LCSW, MFT, PhD, PsyD), practicing for five years or more, and English speaking. Participants in my study will be interviewed by phone or in person on their perspectives about the use of body-based interventions, such as touch and physical contact between mother and child, as well as how you do or do not perceive the body as being important in work with mother-child dyads exposed to intimate partner violence. While my primary goal is for you to define how and if you see the body as being a part of treatment and the subsequent interventions you use, examples of body-based interventions include but are by no means limited to: the use of touch and physical contact between mother and child, observation and processing of body language and/or gestures, the use of movement (such as dance), infant massage, EMDR, and mindfulness, relaxation, and desensitization techniques. As a participant, you will be interviewed one time for approximately one hour. Interviews will be audio-recorded using a digital tape recorder. If an additional transcriber is used apart from myself, that person will be required to sign a confidentiality pledge.

Based on the topic of my research study, minimal risk is anticipated for participants. Because the interview questions focus on your professional work and perspectives, and not your personal experiences, I do not foresee that you will experience significant stress as a result of participation. Some participants may experience some degree of stress discussing clinical work with clients, and if this happens for you please discuss with me any concerns or questions about the study and/or interview. There will be no tangible benefit for participation in this study. Benefits from participation will be the opportunity to share your clinical experience and perspectives in order to contribute to a growing knowledge base on the use of the body and touch within clinical practice. Because there is a growing appreciation for and use of body-based therapies in the mental health field, but still a lack of empirical study on the subject, you may find this opportunity to share your perspectives, whether positive or negative, to be both meaningful and validating. Participation in the study may also provide you with an opportunity to conceptualize your work in new and previously unrecognized ways.

Every precaution will be taken to ensure protection of your confidentiality. Audiotaped in-person and phone interviews will be reviewed and listened to only by me and potentially one other transcriber. If a transcriber other than myself is used, as noted above, s/he will be required to sign a pledge of confidentiality. After identifying information has been removed, my research adviser will also have access to the data collected from interviews to assist with analysis and selection of material for my thesis report. All data will be presented without reference to identifying

information. In presentation of data, only license type (LCSW, MFT, PsyD, etc), and preferred treatment modality will be mentioned and data will be presented as a whole. No specific identifiers will be used. Illustrative vignettes and quoted comments will be disguised. You will be cautioned to be careful to not identify any clients while being interviewed. All data, notes, and consent forms will kept in a secure, locked file cabinet for three years as stipulated by federal guidelines after which time they will be destroyed or maintained securely until they are no longer needed and then destroyed.

Participation in this study is voluntary. You may withdraw at any point in the study up to two weeks after the interview is completed, and may do so by informing me either through written or verbal contact. I am asking for any withdrawal to take place within this time frame so that you have time to reconsider after being interviewed, but not so belatedly as to make it likely I will have already transcribed and analyzed the data. You may refuse to answer any question during the interview process without withdrawing from the interview as a whole. Should you decide to withdraw from the study, the recording of your interview along with any notes connected to the interview will be destroyed immediately. There is no penalty for withdrawal from the study. Should you have concerns at any point about your rights as a participant or any aspect of the study, participants are encouraged to me, or the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Participant Signature

Researcher Signature

Research Contact Information: Danielle Sachs

Please keep the second copy of this form for your records.  
Thank you for your participation.

**Appendix D:**  
**Interview Guide**

## Interview Guide

1. Do you understand the body as being a part of treatment when working with mothers and children exposed to domestic violence? If you do, what are some of the reasons why you include such elements in treatment with these clients? If you do not see the body or physical contact with dyads exposed to violence as being a part of the treatment, can you please explain why you feel this way?
2. Do you make explicit use of the body in your interventions or conceptualization of the case? Examples of body-oriented interventions include the use of touch and physical contact between mother and child, observation and processing of body language and/or gestures, the use of movement (such as dance), infant massage, EMDR, and mindfulness, relaxation, and desensitization techniques. If you do, can you elaborate on how you make use of the body in treatment?
3. Do you see physical interaction as being relevant to treating the attachment relationship between mother and child? If so, can you explain how you understand its relevance, and if not, can you explain why this is not relevant?
4. Do you believe that the use of body-oriented interventions and the use of touch in therapy with mother-child dyads specifically relates to healing the trauma of exposure to domestic violence?
5. What are the potential problems or downfalls, if any, in using the body and touch as a part of treatment?
6. Is there anything relating to this topic that I missed and that you would like to add?
7. So that I can accurately describe the demographic characteristics of my study participants, could you please identify your age, gender, race/ethnicity, number of years in practice, license type, and training discipline?