**Dance and Movement Therapy Processes and Interventions in the Treatment of Children with Anxiety Disorders derived from Treatment Diaries**

**Abstract**

Dance and movement therapy (DMT) offers children a space to encounter strengths and experience a sense of vitality in an aim to increase their sense of confidence and self-awareness, thereby easing their anxiety and/or helping them achieve more adaptive emotion regulation. While previous study findings indicate that DMT effectively reduces symptoms of anxiety such as stress, there is a lack of research focusing on the nature of the therapeutic interventions and how they assist in the treatment of anxiety.

In the current study, DMT techniques and interventions were researched based on their documentation in treatment diaries that track eight long-term treatments of children aged 8–11 coping with symptoms of anxiety. The findings indicate that the therapy shifted between four movement-emotion axes: (1) from disconnection to connection; (2) from avoidance to presence; (3) from merging to separation; and (4) from control to release. For each axis, movement patterns in relation to the other, posture and movement within the space, and transference and countertransference relationships were identified.

Based on the findings, a therapeutic model is proposed. The model leans on various “mirroring” interventions as the basis for forming the therapeutic relationship as well as additional therapeutic interventions involving movement. The model enables the child to explore their experience of the relationship, understand themselves in a new way, and create meaning.

Key words: Processes and interventions in dance and movement therapy; Dance and movement therapy for children; Anxiety disorders in children; Treatment diaries; Movement mirroring; The Paper Chase intervention model

**Methods of Treating Children with Anxiety Disorders**

**Cognitive Behavioural Therapy for Children with Anxiety Disorders**

Anxiety disorders affect a quarter of the population, with general anxiety disorder and social anxiety disorder being among the most common (Taylor et al., 2019). Childhood is a critical period for developing general and social anxiety disorders (Essau & Gabidon, 2013), which disrupt the child’s social, emotional, and academic development (Taylor et al., 2019). They are the most difficult emotional disorders experienced by children and adolescents (Halldorsson et al., 2019) and when untreated, often affect functioning in adulthood (Taylor et al., 2019).

The most common way of treating childhood anxiety disorders is cognitive behavioural therapy (CBT) (Taylor et al., 2019), which has been found to be effective in 60% of cases, mainly among children under the age of 15. This therapy technique places an emphasis on the patient’s behavior, thoughts, and beliefs. The incorporation of positive and calming talk in response to anxiety-provoking thoughts, role play as part of the therapeutic process (Craske et al., 2014), and gradual interoceptive exposure to anxiety-provoking situations while creating new and positive experiences, among other things, by using humor and positive reinforcement (Abramowitz et al., 2012; Craske et al., 2014) have been found to be effective. Other significant factors in the success of the treatment is the relationship between the therapist and the patient, which is formed within a protective and empathic environment (Hoffman, 2019).

While CBT has been proven effective, about 40% of children continue to experience significant levels of anxiety after the treatment is over (Alkozei et al., 2014). Studies show that CBT has low effectiveness in cases of social anxiety (Warwick et al., 2017) and that the technique of generating competing thoughts in response to negative thinking only partially helps to reduce physical symptoms (Alkozei et al., 2015). In this context, researchers found that combining arousal reduction techniques, such as relaxation, with cognitive therapy techniques that help organize, normalize, and explain physical arousal symptoms as part of stress-related phenomena, significantly contribute to the reduction of symptoms (Alkozei et al., 2015). One of the techniques combining a cognitive approach with physical intervention is the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow, 2008), which combines relaxation and self-relaxation techniques that include observing and focusing on the body, accepting phsycial sensations without judging them, and talking about the expereince, emotions, and sensations.

**Dynamic Therapy for Children with Anxiety Disorders**

Dynamic therapy examines the underlying cuases for anxiety in children. According to the dynamic approach, these are linked to developmental conflicts that are related, among other things, to phalic and oedipal urges (Curits, 1979). The purpose of therapy, among other things, is to enable the child to bring their latent impulses to the surface and get to know and accept them without feeling guilty, and thereby to ease their anxiety. The object relations dynamic is recreated within the therapeutic relationship. Therefore, identifying the content arising in transference and countertransference processes is significant for building a treatment and intervention plan. As children express their emotions through action (Chethik, 2000), dynamic therapy for children is generally conducted through play therapy (Baggerly, 2009). In an aim to allow the child to express thoughts and emotions they cannot express directly or speak about in the presence of the therapist, the therapist encourages the use of imagination, humor, and creativity to help the child gain control of their emotional experience and feel some relief. By either playing with the child or doing so verbally, the therapist reflects the content that emerges as they play and thus expands the child’s experience of being seen and validated, allowing for self-expression that leads to a sense of self-efficacy (Schaefer & Drewes, 2009).

In play, the child goes from being passive to being active. Thus, the experience of having no control, which is typical of anxiety-ridden situations, is reduced and in its stead feelings of helplessness along with the need for control and rigidity are expressed (Kra-Oz & Shorer, 2017). One of the main roles of play is to transform raw and overwhelming emotions that arise in children when they experience anxiety and provide a way for these to be expressed (Weitkamp et al., 2018). Within the therapeutic process, the therapist serves as an object that can help the child’s ego expand and gain control. The therapist does so by accepting and joining the child’s inner world and gradually advancing the process by verbally articulating the child’s emotional experiences (Chethik, 2000). A large-scale study conducted among children and adolescents aged 4–21 (n=86) found that the dynamic therapeutic space allowed children to verbally and physically express internal situations of stress, aggression, and conflicting emotions that may be experienced as unbearable, without feeling that they are threatening a significant other or the relationship. The researchers found that anxiety symptoms had significantly decreased by the end of the course of therapy and had remained low a year after it ended (Weitkamp et al., 2018). Another study found that when parents (n=392) of children with somatic complaints focused on their child’s emotional experience, validated it, and gave it meaning, there was a significant decrease in the scope of complaints (Kehoe et al., 2014). In other words, children require an adult to validate and give meaning to their bodily sensations and emotional experiences, without experiencing this as intrusive or frightening. When a child’s physical symptoms are treated while their emotions are ignored, or when their bodily sensations are interpreted in a biased way, expressions of anxiety increase.

**Dance and Movement Therapy for Anxiety Disorders**

Dance and movement therapy (DMT) combines movement and attention to physical sensations using a dynamic approach (Chaiklin & Wengrower, 2015) in an aim to improve emotional and social functioning through the integration of body movements, emotional responses, and self-expression (Pylvanainen, 2010). In DMT for children, the therapist uses guided or spontaneous relaxation, imagery, play, and dance and uses their body to reflect the patient’s movements and adapt themselves to the child (e.g. by referring to the child’s facial expressions, muscle tension, posture, breathing, and voice) (Weitz & Opre, 2019). The child is still in the midst of developing secondary thinking processes, it is difficult for them to express their emotions verbally and their natural inclination is to physically discharge feelings of stress and discomfort (Chethik, 2000).

DMT is based on the assumption that primary object relationships are internalized in the body and imprinted as a somatic memory (Garavito, 2013; Michalak et al., 2009) and that various experiences of movement may assist in learning new ways of forming relationships (Tortora, 2015). The therapist is in a state of psychosomatic awareness, in other words, they are constantly listening to physical sensations and body-related emotions, thoughts, and images as they arise (Pvinle & Parteli, 2014). Awareness of somatic transference and countertransference processes forms the basis of the therapeutic process, as a tool for understanding the therapeutic relationship and the patient’s inner world. Thus, the therapist’s body becomes a transformative space in the therapeutic processes (Vulcan, 2009). Pursuantly, nonverbal interventions that relate to the actions of the body as analytical material promote a direct and unmediated encounter with parts of the self that have been wounded as a result of failures in primary object relationships.

Authentic Movement (AM) is a DMT technique that invites the patient to listen to their bodily sensations and notice how these are expressed in movement. It is based on the assumption that creating a space in which repressed emotions can be expressed through movement can allow parts of the self that have been stunted by avoidance or denial mechanisms to be expressed (García-Díaz, 2018). A study that examined the effect of AM on mitigating anxiety disorders in adults (n=57) found that in the therapeutic processes the repressed emotions that arose were mainly those that are perceived as negative, such as anger, and that there was a decrease in the level of anxiety (García-Díaz, 2018). Another study that investigated the effect of DMT on adolescent girls (n=162) found that following treatment the girls were more aware of the connection between their physical and emotional sensations and that anxiety levels had decreased (Bräuninger, 2012).

In a study that examined the contribution of DMT in the treatment of children aged 6–7 with aggression and anxiety disorders (n=30) researchers found that symptoms of anxiety and aggression had decreased after 10 sessions, compared to the control group that did not undergo treatment (Khodabakhshi Koolaee et al., 2014). In a systematic review of 23 studies researchers found DMT to be effective in reducing anxiety symptoms for children and adults (Koch et al., 2014). The nature of the interventions in these studies included a combination of ballroom dancing (Haboush et al., 2006; Hackney & Earhart, 2009( Creative Movement (Noreau et al., 1995), spatial orientation (Röhricht & Priebe, 2006), and AM (Dibbell-Hope, 2000).

In addition, a study that examined the effectiveness of combining DMT with CBT for children (n=99) found that providing psychological-educational explanations while focusing on the patient’s bodily sensations and the physical expression of their emotions and thoughts contributed to the success of the treatment (Weitz & Opre, 2019). Other studies found that encouraging patients to use their physical strengths and vitality gave them a sense of confidence and promoted self-awareness (Khodabakhshi Koolaee et al., 2014), qualities that are diminished in children dealing with anxiety disorders (Schaefer & Drewes, 2009). In other words, DMT is unique in that it integrates between the body’s movements and its sensations, emotions, and thoughts. It creates a space for expression, regulation, and empowerment, thus assisting patient’s in situations of anxiety. The goal of this study is to identify and map DMT processes and interventions for children with anxiety disorders and consequently propose an initial model for using DMT in the treatment of children coping with anxiety disorders.

**Method**

**The Research Paradigm**

DMT combines various therapeutic disciplines and makes use of multiple therapeutic techniques and interventions throughout the therapeutic process. This calls for qualitative research based on a methodology that achieves a broad and holistic perspective of the nature of these interventions and their effects (Koch et al., 2014). The current study is a participant observation study (Spradley, 1979) in which the therapist is also one of the researchers. The study examined actions taken by the therapist and her patients as well as reciprocal actions that took place within the shared space, as these were documented in treatment diaries during 2013–2018. This is an inductive method for analyzing movement and verbal content, defining areas, and identifying core ideas. Combined with the phenomenological hermeneutics qualitative paradigm, which refers to written text, dance, and art as expressing the wealth of human experience (Tzabar-Ben Yehoshua, 2016), it is commonly used in studies dealing with consulting psychology and psychotherapy (Hill & Hess, 2012) and is based on phenomenological elements from multiple case studies (Yin, 2013). Data analysis in the current study is based on the consensual qualitative research (CQR) method (Hill et al., 1997).

**Participants**

For the purpose of the study, we examined eight diaries tracking the treatment of children aged eight to 11 coping with typical symptoms of anxiety, i.e. night and day terrors, avoiding social gatherings and various experiences, distorted perceptions of reality, irritability, rage attacks, rigidity, and being overly critical. At the recommendation of the school psychologist, the children (three boys and five girls) were referred to and treated by the first author during 2013–2018 for a minimum of 25 therapeutic sessions, with the average course of treatment lasting 25–40 sessions. In four of the cases, the symptoms had passed by the end of the treatment. In the four other cases symptoms had partially improved. At the time of the study, the researcher, a certified DMT therapist, had over ten years of experience and was being guided by a senior instructor who had over 30 years of experience as a DMT therapist and psychotherapist. The therapeutic processes that was documented included 45-minute one-on-one sessions with the children and parent training once a month. The sessions took place in the school in a space that was adapted for DMT, with mattresses, balls of different sizes and textures, fabrics, veils, elastic bands, hoops, sticks, and balancing beams.

**Research Tools**

The treatment diaries were analyzed based on the Milner Method (Halton-Hernandez, 2020) for subjective autobiographical writing and psychoanalytical self-exploration. In her diary, among other things, Milner documented four decades of children’s case studies and her training sessions with Melanie Klein (Haughton, 2014). With the help of Winnicott, Milner established the study of personal diaries as a reflective tool that assists in methodical construction (Halton-Hernandez, 2020). A large-scale study (n=120) found that writing a diary enhanced self-reflection processes (Yu & Chiu, 2019). In addition, self-reflection processes and treatment diary analysis combined with self-reflection and conversations with peers have been found to contribute to the development of critical thinking and the expansion of professional knowledge among the therapist community (Barry & O’Callagan, 2008; Chiu et al., 2013; Yu & Chiu, 2019). This is a reflective process aimed at examining the significance of the action taken and its implications for the various people involved (Shlesky, 2006) in order to produce methodological knowledge that supports and improves the clinical work (Yin, 2013).

Specifically, the diaries contain a documentation of events beginning from the moment the room is entered until the session ends, with reference to the patient’s behavior, including how they treat the therapist, reference to the setting, and the main interventions performed by the therapist. The diaries contain thoughts, questions, and insights that arise and form as they are being written regarding the processes that took place in the treatment room. These are the therapist’s subjective thoughts, attempting to get as close as possible to the objective reality that existed in the room. The diaries document verbal and physical dialogues, the patient’s physical expressions and how they moved, as well as primal sensations, emotions, and physical sensations arising within the therapist during the sessions as part of transference and countertransference processes. The materials appearing in the diaries were written immediately after the sessions and were expanded upon throughout the week, as part of the reflective processes of observing the sessions.

**Data Processing**

To analyze the data we used a sequence of sessions taken from each diary from three points in time throughout the courses of treatment that consisted of 25 sessions. Sessions 1–6 from the start of treatment, sessions 10–15 from the middle of treatment, and sessions 18–25 from the end of treatment. In total, one hundred treatment sessions were analyzed. In accordance with the CQR method (Hill et al., 1997), the analysis process was conducted by three researchers who are also experienced therapists (two DMT therapists and one art therapist). In the first stage, that of content analysis, the content chosen for analysis was coded by each researcher separately to identify domains under which the data could be clustered. These were then discussed until all three researchers agreed on what they should be (Hill et al., 2005). In the second stage, we discussed, identified, and formulated the core ideas common to the therapeutic interventions using systematic comparison and generalization while taking measures to ensure these reflected the data as accurately as possible (Befani, 2013; Hill et al., 2005). At this stage, we determined the heading names of the units of meaning based on the content that emerged from them. In the third stage, which is referred to as cross-analysis, we produced the final themes. We identified therapeutic axes unique to DMT, along which the therapeutic interventions used at various stages of the therapy shifted. Throughout the study, we met several times. In addition to writing together and agreeing on the codes and categories, through peer discourse we also discussed disagreements regarding the analysis process (Hill et al., 2005). The second author, an experienced DM therapist and academic researcher, served as auditor. Her role included ensuring that the raw material had been classified under the right categories, that all the material was represented in a reliable way in the core ideas, that the core ideas had been conceptualized in a manner that retained the essence of the raw data, and that the cross analysis reliably represented the data. She performed this auditing function at each stage of the analysis and writing.

**Professional Ethics and Confidentiality**

To protect the children’s privacy, their names along with any other identifying details have been changed. The parents consented to the use of the treatment diaries for research purposes after it had been made clear to them that their refusal to consent would bear no implications whatsoever. The study was approved by the Faculty Ethics Committee of the University of Haifa.

**Findings**

In the current study, which focused on therapeutic interventions, four main axes were identified: (1) interventions that encourage the patient to take action (n=8), designed to help the patient move from avoidance patterns toward self-efficacy; (2) separation promoting interventions (n=7), to encourage the construction of an identity and the establishment of the self around content related to closeness/distance relations and dependency patterns (3) interventions to strengthen the sense of self (n=7), intended to build a sense of confidence and autonomy. (4) interventions that promote integration (n=7), which emphasize the connection between various aspects of the self. For each of these axes we identified the following four clinical interventions: “mirroring”; “witnessing”; “movement sequences between poles”; and “focusing to heighten awareness.”

The interventions that were identified were classified in reference to the therapeutic axes. We identified seven types of “mirroring” interventions: (1) synchronized somatic mirroring; (2) lingering somatic mirroring; (3) interpretive somatic mirroring; (4) mirroring to encourage initiative; (5) mirroring to bear witness; (6) mirroring to join an illegitimate expression of the psyche; and (7) mirroring to encourage powerful movement (see Diagram 1).

We identified eight types of “movement sequences between poles” interventions: (1) from parts to a whole; (2) sequences between poles using imagery; (3) from the edges to the center of the body; (4) avoidance and presence; (5) closeness and distance; (6) holding and letting go; (7) control and surrender; and (8) experimenting with balance. The choice of using any one of these depends on identifying the content the patient brings to the session and their needs (see Diagram 2).

We identified three types of “focusing to heighten awareness” interventions: (1) joining the emotional experience by listening to the body and focusing on its needs and available resources; (2) verbal mirroring; (3) returning to movement content of the patient’s choosing (see Diagram 3).

Some interventions appeared in all the axes and some appeared uniquely.

**Action Promoting Interventions**

Three main action promoting interventions appeared in the treatment diaries in response to avoidance patterns exhibited by patients (n=3): (a) mirroring to encourage powerful movement; (b) encouraging movement sequences between the poles of avoidance and presence; (c) focusing to increase awareness by listening to the body’s needs and sensations. Table 1 presents a definition of each intervention along with an example. The findings indicate that in some of the interventions, other arts were combined and changes took place along the timeline. Examples are presented in Table 1.1.

**Separation Promoting Interventions**

In regard to merging patterns, seven main interventions appeared in the treatment diaries (n=7): (1) witnessing; (2) mirroring to bear witness; (3) interpretive movement mirroring; (4) mirroring to encourage initiative; (5) expression of movement sequences between the poles of closeness and distance; (6) focusing to increase awareness using verbal mirroring. The interventions are characterizes by an emphasis on strengthening the patient’s connection to themselves and their ability to have a sense of themselves in the presence of another. Table 2 describes the intervention, the way it is performed, and an example from the findings. “Mirroring to encourage initiative” only appeared in the early stage of treatment while “focusing to increase awareness” appeared in the advanced stages of treatment. Examples of interventions in refernce to the timeline are presented in Table 2.1.

**Clinical Interventions for Strengthening the Sense of Self**

In relation to the axis of control and release, seven therapeutic interventions were identified (n=7). The purpose of all of them was to help patients regain a sense of confidence and autonomy. These were: (1) synchronized movement mirroring; (2) mirroring to join; (3) movement sequences between the poles of holding and letting go; (4) movement sequences between the poles of control and surrender; (5) movement sequences from parts to a whole; (6) experimenting with balance; and (7) focusing to bring awareness to emotional and sensory content of the patient’s choosing. Table 3 describes the following interventions: “synchronized movement mirroring,” “movement mirroring to join an illegitimate expression of the psyche,” “movement sequences between the poles of holding and letting go,” and “experimenting with balance,” along with examples. The findings indicate that other art modalities were used only in “mirroring to join an illegitimate expression of the psyche”. In addition, three interventions appeared in the early stage of the treatment: “movement sequences between the poles of control and surrender,” “movement sequences from parts to a whole,” and “focusing to bring awareness to emotional content of the patient’s choosing.” Examples are presented in Table 3.1.

**Integration Promoting Movement Interventions**

As the treatment progresses, the interventions and relationship with the patient become more profound, creating new possibilities for connecting and integrating aspects of the self (see Table 4). Table 4 describes intervention methods and presents examples. The treatment diaries describe seven therapeutic interventions that address the children’s detachment mechanism: (1) lingering movement mirroring; (2) interpretive movement mirroring; (3) witnessing based on resonating mirroring; (4) movement sequences from parts to a whole; (5) movement sequences from the edges to the center of the body; (6) movement sequences between poles using imagery; and (7) focusing to increase awareness. The findings indicate that in some of the interventions additional art modalities were used and that changes took place in relation to the timeline. Examples are presented in Table 4.1.

**Discussion**

The goal of the current research was to identify and map methods of DMT intervention for treating children with anxiety disorders and ultimate identify a therapeutic model, based on the analysis of diaries tracking the treatment of eight children aged 8–11 coping with various symptoms of anxiety. The children had been given long-term therapy, consisting of at least 25 sessions. The study findings shed light on how the therapeutic process manifests in the body of children with anxiety disorders and how various types of physical interventions facilitate the process for the body and psyche. Four intervention axes were identified: (1) interventions for strengthening the sense of self; (2) action promoting interventions; (3) separation promoting interventions; and (4) integration promoting interventions.

Somatic mirroring was found to lie at the heart of the interventions, and seven different types of mirroring were identified. The various types of mirroring allow the patient to have different experiences throughout the course of therapy and serve as a foundation for deepening the interventions as the timeline progresses. Through the prism of child development, these findings serve to expand our understanding of therapeutic processes in children coping with anxiety in order to establish a therapeutic intervention model.

**“Somatic Mirroring” as a “Somatic Holding Function”**

The study findings indicate that “synchronized somatic mirroring,” i.e., joining the patient’s movements, can make patients feel they are in control of the movement and give them a sense of support and confidence. This finding corresponds with the literature that depicts “movement mirroring,” i.e. joining the patient in their movement and implied emotional intention in the closest way possible, as the basis for deepening the intervention and exploring intrapsychic and intersubjective connections within the patient’s world (Shuper Engelhard, 2018).

This can be thought of in terms of creating a new physical experience within the therapeutic relationship that marks the soma’s beingness through the function of “somatic holding.” Mirroring that involves looks, facial expressions, and physical gestures serves as a central function in turning the body’s concrete experience into one that is symbolic and can be represented in the child’s developmental process (Bowlby, 1988). This process is contingent on a parent providing a supportive environment throughout the child’s development (Winnicott, 1951). In his later works, Winnicott delves deeper into the idea of a unified soma being essential in order to have a coherent experience of the self. According to Winnicott, “The mother has the ability to hold the baby so he does not have to know about being made up of a collection of parts. The baby is a belly joined on to a chest and has loose limbs and particularly a loose head: all these parts are gathered together by the mother who is holding the child, and in her hands they add up to one. In failed holding the parts add up to more than one.” (Winnicott, 1989). To “add up to one” - this is essential for integrating the self and is the foundation for what gradually becomes the baby’s experience of self (Winnicott, 1987). Winnicott refers to the mother’s physical holding of the child as critical to the developmental process. In other words, this holding is what creates the experience of “adding up to one” body that delineates the boundaries of the psyche. In the absence of this experience, extinction anxiety arises, as the self requires the body’s boundaries in order to sense its own being, and these are created before consciousness is formed. Winnicott refers to this process, which takes place in the therapeutic space, as part of the “holding function” of therapy (Winnicott, 1987).

To expound on this, we seek to propose an examination of the “somatic holding function” in DMT. “Lingering somatic mirroring” refers to joining the patient’s movement and lingering in its qualities while emphasizing central elements, patiently waiting for a new movement to be born out of the patient’s body. For example, in the case of eight-year-old Ella, the therapist noticed that there was no movement in the chest area. Ella’s main movement pattern was to end a movement phrase by collapsing her chest and staring at the therapist. The therapist repeated Ella’s movement/no-movement, sitting in front her, leaning on one hand with her chest collapsed. By repeating the patient’s body movement, even if it is the slightest of movements, the therapist lingers with the patient in her kinesthetic experience until a new movement is born from within her. Lingering in the no-movement can allow the patient to feel areas that may have been discarded by the soma, parts devoid of movement or awareness, and thus serve as a “somatic holding function.” “Lingering in somatic mirroring” allows the patient to be alone in the presence of another and thus have the experience of their own presence in their soma. We can think of this lingering action as corresponding to the way silence is used in psychoanalytic therapy as means of gauging the development of the patient’s ability to be alone and as a sign of matured emotional development (Berman, 2009). Lingering is necessary in order to strengthen the patient’s sense of self and their ability to separate. It is analogous to an important stage of child development, which paradoxically, is that of being alone in the presence of the mother (Winnicott, 1965).

The findings demonstrate that “mirroring to bear witness” interventions can also assist in separation processes and strengthening the sense of self, as was the case with eight-year-old Na’ama. Here, the therapist made sure that Na’ama led the movement as the therapist gradually got out of her way. In this case, the “somatic holding function” was performed as the therapist witnessed the patient’s movement, which shifted from being alone to being alone in the presence of another. “Witnessing” is derived from AM, which as mentioned above, is a DMT technique based on the assumption that creating a space for expressing repressed emotions through movement can help express parts of the self that have been stunted by avoidance or denial mechanisms. The patient moves in the presence of the therapist, who positions themselves as a witness to what unfolds (Mason, 2009; Pallaro et al., 2007 in García-Díaz, 2018). Findings from a previous study investigating the effect of AM on easing anxiety disorders in adults (n=57) indicate that the repressed emotions that arose during the therapeutic process were mainly those that were perceived as negative, such as anger, and that the level of anxiety had decreased (García-Díaz, 2018).

The current study findings expand the those of the previous study and demonstrate that in treating children, a “witness bearing” presence may facilitate a quiet space for the child to listen to themselves and express difficult experiences, sensations, and emotions. The findings further indicate that the act of bearing witness encourages independent movement, action, and initiative. Perhaps attentive nonjudgmental observation allows children to listen to themselves and express themselves spontaneously and creatively.

**Helping the Psyche Settle within the Soma**

“Interpretive somatic mirroring” can also assist in strengthening the ability to separate and integrating the physical and emotional experience, as is demonstrated in the case of Aviv. Here the therapist joined Aviv in playing with a ball while verbally mirroring the encounter between the ball and various parts of Aviv’s body: “leg,” “hand,” “belly,” “head,” and later by mirroring the representation of the whole body and the relationship between the bodies in the space, by saying “to me,” “to you.” For Aviv, the experience brought up an association of a doll who does not know who she is and the conversation allowed him to connect to the feelings of fear related to the experience of detachment. The movement interpretation created movement along the axis going from parts to a whole and strengthened the psyche’s ability to abide within the soma. This kind of intervention can lead to an emotional connection in places where there was a disconnect from the emotional experience.

In his later works, Winnicott speaks out against the accepted therapeutic approaches that focus on interpretation and awareness. According to Winnicott, in response to an environmental failure, the body loses touch with its needs and finds shelter in mental functioning. In other words, the body develops as a separate entity, detached from its physical and emotional roots. The psyche settles itself in the mind and is governed by it instead of integrating into the psychosoma as a distinct function (Winnicott, 1988). In this context, interpretive movement mirroring can serve as a bridge between movement and interpretation and support the psyche as it settles into the soma. In other words, interpretive movement mirroring supports patients’ connection to sensations, emotions, and experiences of the body as a whole.

When dealing with avoidance and merging patterns, interpretive movement mirroring serves as the foundation for “mirroring to encourage vitality and imitative” and can promote action, initiative, vitality, a sense of separateness, self-efficacy, and power. The interpretation refers to the therapist’s choice of movement content emphasized, for example through a questions-and-answers movement dialogue in which movement qualities of selfhood and independence are emphasized. It can be done by mirroring the patient’s angry face or amplifying vital movements such as clapping and stomping. The therapist recognizes burgeoning signs of vitality in the patient’s movement and by “mirroring to encourage vitality and imitative” effectively legitimizes them and gives them presence.

When dealing with control patterns, we found that “synchronized movement mirroring” and “mirroring to join an illegitimate expression of the psyche” could provide patients with a sense of support and the confidence to express aggression/gentleness that could not be legitimately expressed in their environment or world. These interventions allowed patients to express feelings of sadness and loneliness and discover new qualities such as flow, tenderness, and spontaneity. For example, Ella, at nine years old, was throwing silk handkerchiefs up in the air. The therapist joined her while emphasizing the soft quality of the fabric, gradually moving aside so Ella could continue on her own. Ella adopted the softness of the fabric, a very different quality from the rigid movement she had usually displayed, finishing the session by saying, “I felt I became a handkerchief.”

In conclusion, the holding function is central in assisting the psyche to settle into the soma. The study findings demonstrate how various types of mirroring can serve a “somatic holding function” to support the psyche as it settles into the body, embracing various parts of it that have been discarded, rejected, or invalidated. The various types of mirroring allow for new connections to be created within the self and form the foundation for various therapy processes.

These findings expand our understanding of how mirroring contributes to raising self-awareness (Sandel et al., 1993), promotes empathic processes in therapy (Mcgarry, & Russo 2011) and serves as a tool for understanding the patient’s world through the therapist’s awareness of sensations arising in their body through somatic transference processes (Vulcan, 2009 in Mcgarry & Russo, 2011). It may be that the therapist’s attitude as they mirror the patient’s movements, joining them and enabling them, is what helps reduce the sense of self-criticism characteristic of children with anxiety disorders (Halldorsson et al., 2019). These findings are congruent with the findings of a previous study indicating that when family CBT was used to reduce parental rejection and criticism as opposed to granting children autonomy (n=128) anxiety levels were lowered (Van der Giessen et al., 2019).

**Analytical Processes in Movement**

In more advanced stages of therapy various types of mirroring served as an infrastructure for interventions that included “movement sequences between poles,” enabling the patient to try, experience, and practice relationship patterns and encounter their psychological mechanisms in a safe environment. We identified eight “movement sequences between poles” (see Diagram 2). The choice of using any one of them depends on the content the patient brings to the session and what they require. These findings will serve us in deepening our understanding of DMT interventions and the way the psyche and body’s movement are intertwined within the therapeutic relationship.

The study findings give rise to the assumption that when dealing with the need to control, movement sequences between the poles of “holding and letting go,” “control and surrender,” and “experimenting with balance” can encourage exploration of movement along the axis between holding and letting go and control and release. In addition, these types of interventions can strengthen the patient’s ability to trust their body as an anchor connecting them to a sense of confidence and autonomy. For example, Na’ama, hiding her eyes, wrapped herself in fabric and started walking. The therapist was present as a self-object (Kohut, 1978) and served as a physical and emotional anchor for Na’ama, as she protected her from the sides to make sure she would not bump into anything. The biopsychosocial model refers to feelings as a process of mutual interaction between the limbic areas of the brain and body. Accordingly, the body gathers information about its surroundings through its senses. Humans have the ability to expand their emotional processing beyond the activation of primary motor schemes by creating representations of those schemes in the psyche (Allen, 2013). Thus, when experimenting with balance, the patient can explore her physical stability while relying on the therapist, who provides a transformative space for the patient’s self-exploration. The encounter between the two bodies and the two psyches can help the patient reestablish the experience of control and autonomy within the space.

Creating space for exploration in therapy when dealing with patterns of rigidity and holding appears also in regard to “movement sequences between holding and letting go.” This refers to inviting patients to express emotional content by moving along the axis between holding and letting go. For example, in advanced stages of treatment, a patient entered the room with squirming body movements. In response to this, the content that arose within the therapist was softness as opposed to holding. She suggested working on this pattern through movement – pushing various organs into the floor and letting go onto the floor in various rhythms – movement that created a collapse as opposed to a letting go. Using words and movement, the therapist mirrored the differences and various ways the patient moved, emphasizing the pushing, letting go, and collapsing. At the end of the experience, the patient calmly lay down on the floor, gently moving her hand, marking the birth of a new quality of movement. Listening to the association that emerged allowed a movement space to open up offering the possibility of returning to primary, preverbal, regressive areas in which the psyche had not yet settled into the soma. As the patient entered the room, the therapist translated the information she received by somatically listening to the patient’s movement and the emerging emotional content. She then processed it on behalf of the patient and returned it to her as a verbal suggestion to explore a psychological pattern through movement. The possibility of using the body to explore movement sequences between holding and letting go in the presence of the therapist can allow the patient to embark on an associative movement sequence, one that is somatically held by the therapist and echoed by her both physically and verbally. This intervention can allow a new somatic quality to emerge out of the body and become part of the patient’s psychophysical lexicon. Awareness of somatic transference and countertransference processes forms the foundation of the therapeutic process as a tool for understanding the therapeutic relationship and the patient’s inner world. Thus, the therapist’s body constitutes a transformative space in the therapeutic process (Vulcan, 2009) and pursuantly, nonverbal interventions that relate to the body’s actions as analytical material promote a direct and unmediated encounter with parts of the self that have been wounded as a result of failures in primary object relationships.

In “movement sequences from parts to a whole” interventions the therapist also joins the patient’s movement through an associative stream of consciousness. For example, a patient enters the room crawling on their belly, in response to which the association of a caterpillar arises within the therapist. Pursuantly, the therapist invites the patient to crawl on big sheets of paper holding a color in each hand. The color leaves traces on the paper just as the caterpillar leaves traces in the sand. Based on the traces of the movement on the paper an associative stream of consciousness arises within the patient. Out of the medley of lines, he recognizes shapes and the therapist encourages him to use them to create a narrative, which the patient titles “Self-Portrait.” In a paper titled, *On Not Being Able to Dream*, Ogden (2011) describes a sudden turn that took place three years into the treatment of a patient, when the latter approached him in a way that created inappropriate physical proximity. Ogden surrendered to the flow of associations arising within him, leading him to a significant understanding of the patient and bringing about a new interpretation that effected change (Ogden, 2011). In this case, the patient was speaking himself through his body. The experience was sensory and primal – crawling on his belly. The therapist invited him to go from an associative flow of movement to an associative flow of thoughts, which could allow him to go from a sensory experience to the level of symbolization and conceptualization. It is possible to look at the movement in the room as a flow of beta particles collected through an alpha function represented by the therapist, who surrenders to the associations arising within her, giving them presence as an interpretive action in the space. In other words, by deepening the representation of the caterpillar with the paper and colors, the beta particles were able to turn into alpha particles through a process of symbolization and conceptualization (Bion, 1962).

A type of intervention similar to the “movement sequences between poles” technique appears in other expressive therapies, such as music therapy, where the therapist creates music to mirror the patient’s emotional stance, by either anchoring or contrasting the patient’s melody. In addition, the therapist joins the content the patient brings to the session and improvises on its themes or improvises together with the patient (Stern, 2010). Improvisation is an open-ended and ongoing process that includes among other things emotional expressions of laughter, struggle, disagreement, and misunderstanding. There is no fixed method regarding the structure of the intervention (Stensaeth, 2017). In other words, similarly to the findings of the current study, the therapist must be open to what unfolds and respond creatively according to the patient’s needs.

**Applied Implications**

The study was conducted based on the qualitative paradigm of hermeneutic phenomenology for multiple case studies using participant observation. It involved shifting between the personal and professional by reflectively observing the action during and after its occurrence and documenting the process in treatment diaries. These served as a basis for the methodical construction of clinical diagnosis and intervention processes. The methodological foundation of this study can serve other clinicians seeking to investigate and conceptualize the therapeutic processes that take place in the treatment room. This research process promotes the connection between clinical work and research and contributes to professional development and improvement.

The possibility of encountering and experiencing the emotional patterns described in the study corresponds with the principle of immediacy, which encourages a focus on the experience as it occurs during the therapeutic encounter, allowing the patient and therapist to experience and explore patterns that arise in the relationship (Clemence et al., 2012). Theories of self refer to sensations and experiences as change agents in the therapeutic process. These include attention to physical sensations, visual imagery, the choice of words used in conversation during the session, and nonverbal aspects of the relationship, based on the assumption that the creation of a new experience within a relationship is a therapeutic process (Curtis, 2012). In this sense, the “movement sequences between poles” technique appears to combine the two main approaches to treating anxiety in children, i.e. dynamic play therapy (Baggerly, 2009) and CBT, which includes gradual exposure to anxiety-inducing situations and sensations (Matweychuk, 2014). This indicates that DMT combines various therapeutic disciplines. It involves thinking about anxiety patterns and motivations, leading the therapist to use symbolic and play-related interventions characteristic of the dynamic approach, in addition to focusing on the experience as it is unfolding and the therapeutic relationship as change agents that promote awareness. In addition, DMT interventions allow patients to experience anxiety-inducing content in a safe environment, which is a type of intervention characteristic of CBT.

Based on an examination of the study findings in reference to the timeline, we derived an intervention model that can serve as a referential anchor for the therapeutic process. At the core of the interventions are identification, joining the content brought by the patient through various types of mirroring, expanding it through “witnessing” or by using “movement sequences between poles,” and by using colors, sounds, and conversation to promote “focusing to increase awareness.” All of these are used and adapted based on the patient’s needs and stage of treatment. In the early stages of treatment various types of mirroring are required in order to establish the relationship and the language of movement as a therapeutic language used in the room. These constitute the basis for deepening the therapeutic interventions though “movement sequences between poles” at a later stage of the treatment. The course of treatment develops much like a spiral, in a nonlinear progression, as space is created for the therapist and patient’s creativity to emerge. Between primal levels of sensory expressions through movement and higher levels of perceptual or cognitive-symbolic emotional expressions - this type of movement can facilitate an integrative experience of the self (see Diagram 4).

The model we propose corresponds with the “Expressive Therapies Continuum” model, which is an intervention model from the field of art therapy that proposes working at various levels of processing while moving along axes. Thus for example, working with materials that encourage sensory movement can help patients come in contact with unconscious parts of the self and expand their ability to tolerate and observe difficult sensations and emotions. This movement toward formalistic work that gives form to the emotional experience can help patients gain awareness, a deeper understanding of their inner world, and a connection to themselves (Hinz, 2015).

**Study Limitations**

The study is based on treatment diaries documented by a clinician-researcher who was part of the research team, which can potentially lead to subjective bias. In addition, the study included no empirical indexes for measuring the effectiveness of the treatment, such as symptom-level indexes and self-efficacy indexes. Finally, the sample size is relatively small, and therefore caution should be applied in regard to generalizing the findings.

**Recommendations for Future Research**

Future research is important for testing the therapeutic model. Quantitative studies could investigate how and which type of change is possible for patients coping with anxiety disorders. In addition, based on the study findings a diagnostic model utilizing the various types of mirroring specified here in order to understand the patient’s physical and psychological characteristics could be developed. Furthermore, the findings indicate that therapy often touches on primary object relations in the nonverbal stage. Future research could examine the use of the interventions identified here as a means for supporting separation processes in dyadic therapy.

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