

Dance/Movement Therapy in Response to Continuous Race-Based Trauma

Aliesha Bryan

May 2021

Submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Dance/Movement Therapy
Sarah Lawrence College

Abstract

Trauma is concomitant with a lack of safety; as such, where there is a threat to safety, there is likely to be trauma. Afrodescendants living in the United States, through an ongoing lack of human regard, are often powerless to ensure their safety, and are regularly subjected to continuous, race-based trauma. Racism is deeply embedded in the nation's institutions as well as in every relationship, and this deeply pervasive and penetrating ideology influences strongly how individuals of any race interact with others. Race-based aggression, from micro- to macro-, has a profound and continuously traumatizing effect on Afrodescendants, with similarly profound effect on how they move through the world. Trauma-informed dance/movement therapy can provide a framework for a corrective relational experience, in which safety can be created and experienced and in which co-regulation, empathy, and recognition abound. While there is no post-traumatic environment within which Afrodescendants can effect the healing process, dance/movement therapy offers opportunities to manage overwhelming levels of stress while providing access to the positive regard, support and esteem often denied in daily life in America.

Keywords: dance/movement therapy, race-based trauma, stress, polyvagal theory, attunement, safety.

Continuous race-based traumatization in the experience of Afrodescendants

The body is where we live. It's where we fear, hope, and react. It's where we constrict and relax. And what the body most cares about are safety and survival. When something happens to the body that is too much, too fast, or too soon, it overwhelms the body and can create trauma. (Menakem, 2017, p.7)

Trauma is not entirely, or even primarily an emotional response. Rather, trauma happens in the body. A spontaneous protective mechanism that the human body uses to stop or thwart further (or future) potential damage, trauma is the body's protective response to an event – or series of events – that it perceives as potentially dangerous. Regardless of whether that perception is accurate, inaccurate, or imagined, a reflexive trauma response may become embedded in the body in the aftermath of the highly stressful or traumatic situations. This process, which happens at lightning speed, can manifest in a variety of ways (Menakem, 2017).

The well-known “fight-or-flight” response has been expanded since its original conceptualization. Mencagli and Nieri (2019), for example, talk of “freeze”, “flight”, “fight”, “fright”, and “faint” as the bodies various reactions to stressors. The freeze response, for example, occurs when a person is confronted with an approaching but not necessarily immediate threat. Freezing in a state of alertness is thought to allow the individual to evaluate the level of danger from a stationary position. Both flight and fight are understood to follow that state of alertness, and one or the other occurs once the body has determined whether escaping or combating the threat allows for the greatest chance of survival. Fright, sometimes also referred to as “collapse”, occurs when the body responds to a threat with inaction. The body continues to be conscious, but the senses are “numbed” to avoid yielding to the overwhelming experience. Faint occurs when the body is unable to handle the stress and a sudden loss of consciousness occurs (Mencagli & Nieri,

2019). Menakem (2017) states that “an embedded trauma response can manifest as fight, flee, or freeze – or as some combination of constriction, pain, fear, dread, anxiety, unpleasant (and/or sometimes pleasant) thoughts, reactive behaviors, or other sensations and experiences. This trauma then gets stuck in the body and stays stuck there until it is addressed” (p.7). Interestingly, as Menakem (2017) asserts, an individual can have a trauma response to any perceived threat; that need not be only a threat to physical safety, but to the safety – or perhaps the *integrity* or *intactness* of what one says, thinks, cares about, believes in or *yearns for*.

We see that safety, or the lack thereof, and trauma go hand in hand. Where an individual has been *powerless* to ensure their safety, integrity or intactness, there is likely to be trauma. As Menakem (2017) puts it, “the body either has a sense of safety or it doesn’t” (p.7).

There are many ways in which the safety, integrity and intactness of Afrodescendants are threatened, generally on a daily basis. One of the most damaging ways by which it occurs, is through an ongoing lack of human regard for individuals who, as Menakem (2017) describes, live in black bodies. The United States of America faces a grave relational crisis. Indeed, the country has been facing this crisis for some time now, but the summer of 2020 – which directly preceded the writing of this paper – brought about a reckoning of sorts. The generalized stillness and forced idleness engendered by the COVID-19 pandemic and varying degrees of enforced stay-at-home measures transformed Americans into a kind of captive audience, while the wide reach of increasingly available and used social media platforms made it so that every person in the country – and indeed around the globe – had a front-row seat for the spate of murders of African American people and other unmistakably race-driven injustices that opened the world’s eyes to a different kind of epidemic, one that has raged virtually unchecked due to the apathy of governing authorities and, sadly, the individuals most empowered to effect change.

The murder of George Floyd by officers of law enforcement shocked many into looking more closely at how African Americans are treated in the United States of America. Days after Mr. Floyd's death, the BBC Reality Check Team (2021) reported what is far from novel information at this time in history: that African Americans are more likely to be fatally shot than any other race by the police; that they are arrested at a higher rate than white Americans for drug abuse; that they are imprisoned at five times the rate of white Americans, representing almost a third of the country's prison population. Pitner (2020) asserts that while American society is defined by race, it spends little time analyzing the history of its racial divisions, preferring to believe that it is following a path that inevitably leads toward racial equality. The nation allows itself to believe this by holding onto a narrative of progress, one that was strengthened by the 2008 election of Barack Obama, but which was swiftly shattered by the 2016 election of Donald Trump, whose campaign slogan championed America's divisive past as a form of progress, and whose harrowing presidency was peppered with casual yet blatant disregard for critical disparities and inequalities.

A relationship is defined as the sum of interactions between two individuals. Racism permeates, to varying degrees, *every* relationship within the United States of America. It strongly influences how individuals of any race interact with others, and it has a profound and continuously traumatizing effect on people living in black and brown bodies. Racism, and its manifestations, affect how people living in black and brown bodies are treated and, consequently, how they move throughout the world. Racism is so deeply embedded as normal practice in institutions that it is called institutional or systemic. Racism is an enduring and pervasive aspect of American society, deeply embedded also in interactions between individuals. Racist ideology, while abstract, finds concretization in the actions of those who consistently absorb its precepts. Healthcare – access and

quality of care – is one significant area that is adversely affected through interactions tainted by pervasive – albeit at time unconscious – racist influence.

Racism has been acknowledged as an ongoing public health crisis deserving of attention by many entities, including the American Public Health Association (APHA). Defining racism as “a system of structuring opportunity and assigning value based on the social interpretation of how one looks that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources” (APHA, n.d.), the APHA recognizes how through the structuring of opportunity and assignation of value, the health of the nation is thrown into doubt by disallowing some from attaining their highest level of health.

The lethal COVID-19 pandemic also exposed anew racial inequalities within the nation. Louis-Jean et al. (2020) call not only for an urgent plan of action to respond to the challenges of the pandemic, but to *any* health threat in African American communities. Embedded racism in the healthcare system and the socioeconomic and health disparities worsen the effects of the pandemic on this population. While COVID-19 might be new, the effects on this population that have been witnessed are deeply rooted in continuous and historical plight of African Americans in this country. The Centers for Disease Control and Prevention (CDC) provide a dry and bleak picture of the suffering of racial and ethnic minority groups. Across all the categories of life disrupted by the pandemic, minority groups have been disproportionately affected by COVID-19: greater difficulties finding and maintaining affordable, quality housing; lack of access to reliable transportation; less access to quality health care, health insurance and culturally responsive health care; disproportionate representation in “essential work” settings; generally lower incomes and greater barriers to wealth accumulation and greater debts, all of which complicate the management

of expenses, payment of medical bills, the securing of reliable childcare and access to affordable, quality food (CDC, 2020).

These inequities, however, are unsurprising given that America has a long history of creating countless laws and policies intended to sustain the racial divide. Pitner (2020) elucidates further, noting that American norms extending to housing, education, employment, healthcare, law enforcement and environmental protections including clean drinking water, have disproportionately harmed African Americans and other communities of color in order to sustain racial division and white dominance. The murder of George Floyd represents a continuation of the systemic criminalization and oppression of black life in America that has always been the American norm dating back to Jim Crow, segregation (which means apartheid), and slavery. During Jim Crow, while the government could not legally deny black people their humanity, it *could* deny them the services that are afforded to human beings, including education, housing, and employment, while treating them in such a way as to reinforce “their place” as a perpetually subjugated people. Large prisons were erected on former plantations; black people were arrested for minor crimes and given long prison sentences doing manual labor on the same land their ancestors were forced to work as enslaved people. As a result of Jim Crow, millions of African Americans fled the neo-slavery and terror of the South during the Great Migration, and racial tensions spread as other American cities did not welcome these domestic refugees. While the civil rights movement of the 1960s effectively ended Jim Crow, and African Americans began reclaiming the rights, specifically voting rights and *freedom of movement* that had been previously won following the end of the Civil War, it continues to be a long road to dismantle systemic and legalized racism and segregation (Pitner, 2020).

The unjust killing of black people by the police and racist vigilantes remained the norm even during Obama's hope-restoring presidency, but America – where divisions and inequality are forged in its ethnocidal roots – still has much work to do to *begin to* repair racial tensions. Understanding that racism taints relationships and interpersonal interactions at their most basic level, then change must also occur at the level of interpersonal interactions and – to go even further – with attention paid to how the bodies of the individuals involved are interacting.

Exhausting the black body

While much research has been devoted to the impact of traumatic events on individuals and, more specifically individual bodies, including how trauma affects and modifies brain function and alters interpersonal interactions, we must also note that the impact of trauma can and does extend beyond those who directly witness or experience an event that overwhelms their coping capacities. The kind of structural violence described in this paper, of which continuous race-based trauma is a result, prevents people and communities from meeting their basic needs, reverberating across the population, and breaking down social networks, social relationships and positive social norms across communities. This is of particular importance since such social networks – as we will see below — could otherwise be protective against violence and negative health outcomes. Polyvagal theory, which looks at the neurobiology of social behavior and is often employed to both understand and rehabilitate the disruptive effect of trauma, speaks of a protective “social engagement system” (Porges, 2017). The theory also recognizes and asserts the importance of connecting and “coregulating” with others as a biological imperative. Inherently social beings, humans normally utilize the above-mentioned social engagement system to do just that.

While new models are emerging to counter the effects of trauma, promote community healing and foster community resilience, there has not been an existing framework for

understanding, addressing and preventing trauma at a community or population level. (Pinderhughes et al., 2015).

We should not be surprised to read that “exposure to human rights violations (HRVs), coupled with enduring deprivation and adversity, affects mental health outcomes” (Nickerson et al., 2014, p.172). Such exposure is known to create the risk for psychological disorders, such as post-traumatic stress disorder and depression; however, these diagnostic categories may be inadequate to describe the effects of such circumstances across a range of domains. Nickerson et al. inventory a range of other reactions found in research, and they include: “profound and impairing changes to self-concept, self-efficacy, and core existential beliefs, as well as pervasive feelings of anger, humiliation, and betrayal” (p. 172). One thing we know about trauma response is that the physical reactions that may have been appropriate in the face of a trauma-inducing event, as well as those interpersonal behaviors perhaps developed as part of a set of coping mechanisms, may no longer be appropriate at other times. Long after the event or events, traumatized individuals are known to exhibit disruptive behaviors, and may have difficulty getting along with peers. However, where continuous race-based trauma is concerned, the events responsible for the trauma are not securely in the past; rather, they are systemically repeated at frighteningly regular intervals. And, as such, the body of an individual struggling with this particular phenomenon will consistently be in a state that supports defense rather than health and restoration.

Racism, such as it is experienced in the United States of America, is a human rights violation, as it denies persons who are not identified as white the same treatment offered to those who are identified as such. When entering any environment where contact with others can be expected, black Americans are constantly engaged in the office of evaluating the level of risk to the physical and mental integrity present in that environment. They are constantly in the state of

defense. Let us consider what it means for black Americans to have to be constantly vigilant in the environments in which they move due to the consistent threat that pervasive racist ideology poses. In the face of such consistent threat, continuous experiences of re-traumatization (from, for example, persistent and consistent levels of violence carried out against communities of color) and a continued need for vigilance, how does an individual live, work or live and work with others?

Shervington (2018) writes of the exhaustion incurred over a lifetime of continual resistance and struggle, noting that longitudinal studies have revealed black people and their communities to be burdened with more than mere weariness. Race-based and -driven “chronic disconnections”, stressful interactions that include but are not limited to harassment, confrontations and/or arrests by police for seemingly innocuous actions, point to a disturbing reality that to be an Afrodescendant in the United States of America means to always be potentially trespassing, a potent message that severely limits the sense of safety, comfort, and mobility of individuals living in black bodies while substantially increasing levels of anxiety while conducting the routine activities of daily life. Such incidents highlight the incursions that can take place where empathy is lacking and race-based power structures are reinforced. Research has established that black people and their communities are forced to adapt to psychosocial stressors and adverse environments, the cumulative negative impacts of which eventually deregulate the body’s attempt to retain equilibrium (Shervington, 2018). As such, the pervasiveness of racism, or as Shervington puts it – “white supremacy’s insidious existence in the societal, political, and economic structures in which we have lived for centuries” (p.37) has a compounding negative force. The “traumatizing terrorism of white supremacy has been the disruption and damage of all aspects of Black people’s health – mental and physical” (Shervington, 2018, p.37).

Shervington (2018) asserts that while undoubtedly a black child's development is heavily influenced by dynamics with their caretakers, it is ultimately the sum total of multiple interacting forces that make up the heavy burden that black people carry. She writes:

In spite of all the oppressive barriers, losses and holes, Blackness and Black people have survived. One might argue that our existence is evidence of and a tribute to our ancestors' courage, resistance, and resilience – from the slave ships and cotton fields to the White House. Evidence that Black optimism, hope, and joy still prevail. But, there comes a point when the beaten up, punch-drunk prizefighter can no longer stand up and throw another punch. His/her legs are smashed and broken and he can no longer protect, hunt-gather for his family and community, or help shape the future for his child. On an individual and community level, our mission has to be curtailing the frequency of our culture taking shots in the boxing ring, reducing the stress on its plasticity, and restoring its beneficial function to us all. (Shervington, 2018, p. 59-60)

Shervington is writing about “allostatic load”, the cumulative burden of chronic stress and life events (Giudi et al., 2021) or more precisely “allostatic overload”, which occurs when environmental challenges exceed an individual's ability to cope (Giudi et al., 2021). Allostasis is a term that refers to the adaptive processes that maintain homeostasis through the production of “mediators”, such as adrenalin, cortisol and other chemical messengers. While those mediators promote adaptation in the aftermath of acute stress, they also contribute to allostatic overload, the wear and tear of the body resulting from the repeated activation of compensatory physiological mechanisms in response to chronic stress – in other words, from being stressed beyond repair. Shervington (2018) expounds on injurious cultural experiences, injurious childhood experiences, injurious societal experiences, and injurious community experiences, all of which contribute to

pushing black individuals and communities beyond the “stress yield point”, *irrevocably* tiring out the black body.

Does a post-trauma environment exist in the context of continuous race-based trauma?

In 1992, Judith Herman coined the term “complex post-traumatic stress disorder” (complex PTSD), which refers to, among others, personality changes involving deficits in emotion regulation, self-identity, and capacity to engage in adaptive relationships, in “an attempt to capture the depth and chronicity of psychological disturbances following repeated interpersonal traumatization” (Nickerson et al., 2014, p.172). Interestingly, as the authors note, studies on the subject have recorded a substantial number of persons that survived human rights violations without developing significant formal mental disorders or functional impairment, opening the door for evaluation of what factors may contribute to recovery from such stressful events (Nickerson et al., 2014). That said, research investigating complex PTSD and related disorders of excess stress are known and have been criticized for their “inadequate coherence of criteria, lack of specificity and poor stability across populations” (Nickerson et al., 2014, p. 173). As such there has not been to date a universally accepted, comprehensive or unified construct that adequately encapsulates the wide-ranging effects of exposure to human rights violations.

Nickerson et al. (2014) note that much research attests to the pivotal importance of the post-trauma environment in promoting psychological recovery following exposure to a traumatic event. The authors further note that

evidence-based models for the treatment for PTSD developed in Western settings focus on assisting the survivor to process the traumatic experience in the context of safety and to correct maladaptive and unrealistic appraisals of the trauma, the self, and the world. These

models implicitly assume an objective level of safety in the survivor's environment, and the availability of disconfirming information and healing social experiences (Nickerson et al., 2014, p. 182).

However, as we have begun to see the context in which Afrodescendants living in the United States of America live is not one that can be considered a "post-traumatic" environment, and the consistency with which race-based traumatic events occur strongly challenge any attempts to repair beliefs, rebuild identities or promote well-being. Instead, consistently reoccurring trauma tends to preclude the objective safety that has been established by research as necessary to recover from the effects of continuous race-based trauma.

Nickerson et al. (2014) assert that the institutions necessary to facilitate post-trauma recovery, in particular through the provision of health care, mental health services and social welfare, can also play a role in the perpetration of violence or oppression. If, as Porges (2017) asserts, safety and safe states are a prerequisite for pro-social behavior, then educational institutions, government infrastructure, and medical treatment centers, among others, must have a hand in promoting such states of safety. There are questions to be reckoned with, including the priorities of culture and society in respecting individual needs for safety. Porges states that "we need to understand what features in the world disrupt our sense of safety and realize the cost to human potential of living in an unsafe world" (Porges, 2017, p. 47)

In what helps to establish another parallel with the condition of Afrodescendants living in the United States, Nickerson et al. (2014) notes that when perpetrators of violence live side-by-side with their victims, particularly if the governing regime is still in power, this is conducive to a situation of impunity wherein victims have no recourse for the acts that have been perpetrated against them. Similarly, Afrodescendants, for example, must continue to live in neighborhoods

patrolled by the same law enforcement officers that target and victimize them, work in spaces where microaggressions take place, and live under rules and regulations that regulate what they do or do not have access to. They must even contend with active efforts to curtail hard-fought gains, such as the introduction of legislation to severely restrict voting rights in a number of states.

There is no post-trauma environment for Afrodescendants. Structural, physical, psychological, and emotional violence continue, making the acquisition of a felt sense of safety doubtful, if not ill advised. The current context continues to have a substantially injurious effect on the well-being of Afrodescendants by providing a hostile setting for recovery.

The injurious effect of misrecognition and the restorative effect of attunement

Recognition and mutuality do not exist on a wide enough scale in the United States of America to even begin to ensure the well-being and restoration of the mental health of millions of the traumatized Afrodescendants living there. That concern underlies the damage done daily to this population and may also be key to restoration and healing – of both the individuals and the nation as a whole. Through what she terms a “recognition framework”, Harris-Perry (2011) discusses the shame and stereotypes facing black women, in particular, in America. Referencing the “crooked room” (a term that harkens back to cognitive psychology research studies in which individuals, when placed in a crooked room, either aligned themselves in relation to a crooked room while believing themselves to be upright or managed to find “true north”, as it were, in spite of the unevenness of their surroundings), Harris-Perry (2011) delves into the “politics of recognition”, the intricacies of the social contract, and the importance of being accurately “recognized” in the public space.

While the focus of this particular Harris-Perry (2011) work is on black women, the idea that misrecognition extends to black people in general is not a stretch. Referencing luminaries such

as Hegel and Arendt, Harris-Perry (2011) asserts that *mutually affirming recognition* allows citizens to operate as equals within the confines of the social contract – that foundation of democratic citizenship – according to which individuals consent to subject themselves to rules, constraints and collective burden imposed by the state in exchange for the safety and services provided by that same state. A fair system is one that offers its citizens equal opportunities for public recognition, and yet Afrodescendants often suffer misrecognition in the form of stereotype and stigma. People are willing to do the work of citizenship because the public sphere offers such a chance for recognition, and they are willing to relinquish certain freedoms because of their need for safety (Harris-Perry, 2011); however, recognition and safety cannot be said to be inherent to the experience of black Americans in spite of their efforts.

Harris-Perry (2011) argues that marginal and stigmatized group members face fundamental and continuing threats to their opportunity for accurate recognition. Not only are members of such groups denied access to the public realm or have their social possibilities limited by their membership to such groups, they – as part of groups that are “despised” – lose the opportunity to experience the public recognition for which the human self strives. Also, if the group is itself misunderstood in the greater context, then to the extent that one is seen as a part of said group, the seeing of such an individual will be inaccurate. Inaccuracy of seeing, or misrecognition, is painful. Afrodescendants, as members of a stigmatized group, not only lack opportunities for accurate affirming recognition of the self, they have no reasonable expectation of being properly recognized in the public sphere (Harris-Perry, 2011).

Harris-Perry (2011) asserts that recognition is a useful framework because it emphasizes the interconnection between individuals and groups. Why should the reader be concerned with misrecognition as opposed to other seemingly more pressing demands? It is because subordinated

and oppressed groups are harmed by misrecognitions, which engender feelings of shame. Misrecognition, whether out of malice or caused by ignorance, is a failure to extend due respect or esteem, and in the context of continuous race-based trauma is actually inherent to institutionalized patterns that prevent Afrodescendants from fully participating in life.

While misrecognition and disconnection are central, although not exclusively so, to the relational crisis currently existing in the United States, racism – a social constructed and institutionalized hierarchization of peoples based on skin color that subsequently determines the quality of treatment one receives across all aspects of life – lies at the center of why black Americans are consistently and stubbornly misrecognized, encouraging a state of disconnection whenever they should venture out of the margins and into “the center”.

Misrecognition is tiring, and it can take a variety of shapes. Misrecognition in the form of stereotypes, like shapes, are both known, characterized and thereby limited by their definitions, forcing Afrodescendants into containers that they might not willingly enter or inhabit if they had the choice. And yet, they are too often only seen with respect to those imposed limitations. Afrodescendants are often subject and/or reduced to shaming stereotypes. For women living in black bodies, for example, such misrecognition often means that they are

diagnosed very differently from white counterparts who present with the same symptoms. For instance, black women have considerably higher rates of anxiety disorders than white women. Blacks are diagnosed with higher lifetime rates of simple phobia, social phobia, and agoraphobia. Therapists tend to view African American women as anxious or phobic while perceiving white women who describe similar emotions and behaviors as sad and depressed. Black women are more likely to be described by therapists as hostile and paranoid, and diagnosis for black women is inclined to be more severe than for white women. In

these diagnostic differences we see the operation of social construction of black womanhood that disallows sadness. Therapists are less likely to perceive a black woman as sad; instead, they see her as angry or anxious. (Harris-Perry, 2011, p. 92-93)

Shame, which was not treated seriously as a clinical concern until the late 1980s, is also limiting. Shame is thought to have three components, the first of which is social and suggests that individuals do not feel shame in isolation but rather in response to a real or imagined audience, and then only when a social boundary or community expectation has been violated (Harris-Perry, 2011). Individuals experience shame when they fear exposure and evaluation by others and often feel, in response, a physiological urge to hide and retreat (Harris-Perry, 2011). The author states:

Black people are like other individuals: when asked to recall shameful events, they talk about having a strong desire to hide, escape, or disappear, and they display the physical postures of slumping, dropping the head and avoiding eye contact. Laboratory experiments have shown that shame causes the body to release the steroid hormone cortisol. The shame-cortisol response is similar to the fear-induced “fight-or-flight” response. When we feel ashamed, our bodies react with hormones that tell us to save our social selves by fleeing. Fight or flight is an adaptive response when we need to react quickly to physical danger, but if we face chronic exposure to such danger, the physiological response becomes a key element of post-traumatic stress disorder. The shame-induced cortisol response can be similarly debilitating when cortisol levels are chronically elevated. People who repeatedly suffer social rejection become vulnerable to a variety of health effects. Elevated cortisol can lead to weight gain, heart disease, hardening of the arteries, and decreased immune function. (Harris-Perry, 2011, p.106).

On one level, this problematic messaging, which greatly influences interpersonal interactions, has to do with the creation of boundaries, lines of demarcation, with varying levels of porosity, that determine who can be where, when, and the conditions of entry or denial of entry. Boundaries can be tangible and visible, such as in the case of a fence or other physical obstacle to entry, or they can be intangible and invisible but known or assumed, such as redlining. Boundaries can be theoretical. They can be legally binding and subject to enforcement. Boundaries can also be internalized, such as an expectation or understanding that one should not go somewhere, that it would be safer not to go somewhere, or that one would not be welcome somewhere. In such cases, the potential consequences serve as a deterrent. For black men and women in America, boundaries around their movement, tangible, intangible, legal, enforced, internalized, and assumed are woven throughout American history, and the potential consequences of movement outside the realm of what is allowed have a strong impact on how black men and women move. Internalized restriction, as black men and women attempt to navigate potentially hostile terrain, is a phenomenon that has not been exhaustively – or even sufficiently – explored. Continuous and consistent race- and identity-based traumatization of black Americans leads to inhibition of movement in public spaces.

Black Americans are aware that others see them through a distorted lens that renders them socially unacceptable, and in this sense, as Harris-Perry (2011) writes, shame is the psychological and physical effect of repeated acts of misrecognition. Shame can and is used to regulate societies, in particular through real or anticipated social sanctions that punish individuals for violating group rules or refusing to stay within the lines of what is considered acceptable behavior and thought. Knowing this, we begin to understand the dangers inherent for black Americans in simply existing in this fraught social space. One thing that black Americans rarely experience in society is a sense

of safety, and yet safety is considered necessary not only for pro-social behavior but is essential to treatment of most personality disorders, including trauma-based disorders.

We can see how in such a setting the continuous and repetitive occurrence of race-based traumatization can cement altered processes, beliefs, and perceptions. However, healing and adaptation can be facilitated through the provision of safe, secure and warm environments. With the understanding that trauma leaves indelible marks in the body, and specifically within the body's nervous system, dance/movement therapy is uniquely placed to intervene and promote healing. Dance/movement therapy is inherently relational. Cantrick et al. (2018) discuss the use of dance/movement therapy to address oppression in the context of the therapeutic relationship.

We have examined continuous race-based trauma as it affects individuals in relationship to one another and within the community and societal frameworks. It makes sense then that oppression, its markers, and its effects also show up in the therapeutic context. As such, promoting the healing of Afrodescendants struggling with race-based trauma is not only a matter of introducing effective interventions, but understanding that how the therapist and client engage in relationship itself is crucial. According to Cantrick et al (2018), a socially just dance/movement therapist will take power differentials, personal bias and personal limitations into consideration: "The body becomes a vehicle for understanding how oppression is unconsciously perpetuated through the bodies of both oppressed and dominant groups." (Cantrick et al., 2018, p. 193) Oppression impacts the physical expression of the oppressed. Understanding that as well as the fact that power and oppression are often also communicated non-verbally, with messages passed from one body to another, Cantrick et al. (2018) advocates for a paradigm shift that will interrupt the dominant narrative "that wrongness lies within the bodies of marginalized groups" (Cantrick et al., 2018, p. 194). Dance/movement therapy, in a context in which the body's relevance in the

enactment of oppression and oppression's role as a traumatizing experience are understood, can act as a healing and therapeutic modality to counteract the harmful effects of oppression (Cantrick et al., 2018). Cantrick et al. (2018) asserts that the healing work for the Afrodescendant population becomes even more possible if and when a dance/movement therapist is able to "shift their nonverbal behavior" in a way that supports "the empowerment and bodily authority of their clients" (Cantrick et al., 2018, p.195).

The body itself can present limitations in this therapeutic work because trauma can have a dissociative impact. Consequently, the therapeutic process should make space for the continual assessment of sensation and exploration of what movements are tolerable interventions for individuals impacted by continuous race-based trauma. A combination of recognizing and acknowledging what is brought into a therapeutic session in terms of "oppression dynamics", bias or traumatic experience and incorporating body-based interventions that help a client to resist oppression are an important avenue of investigation (Cantrick et al., 2018).

Discussion

Addressing the somatic imprint of continuous race-based trauma

Dance/movement therapy, through which the information gathered from bodily sensation and movement inform the psychotherapeutic process, promotes emotional, social, cognitive and physical integration (American Dance Therapy Association, 2016). The relationship with, and support from, the dance/movement therapist can enhance changes that occur on a movement level and are thought to be enhanced by the relationship with and support from the therapist (Dieterich-Hartwell et al., 2020).

Empathic responses from the therapist with regard to the client are crucial, as such responses allow the client to feel respected and effective, and enable the growth of trust and positive expectations for the relationship (Jordan, 2018). Trauma tends to isolate individuals from their bodies (Cantrick et al., 2018), while also complicating their relationships with others; dance/movement therapy can help a client begin to restore their capacity for connection to others as well to reconnect with their embodied experience.

The somatic imprint of oppression is much like that of episodic trauma; consequently, individuals struggling with continuous race-based trauma may experience somatoform dissociation and increased constriction of movement. Afrodescendants, therefore, may find that the impact of oppression limits their access to genuine expression and human connection, further isolating them (Cantrick et al., 2018). Dance/movement therapy addresses those impacts by assisting clients to become more aware of their bodies, increasing tolerance for sensation, accessing greater movement repertoire, and reclaiming some bodily authority or agency within their lived experience of oppression (Cantrick et al., 2018). Through sensitive embodied interactions with awareness of how posture, gesture, pace, eye contact, touch, space, and more and be used to create safer, anti-oppressive spaces, oppression and power dynamics can be explored and challenged.

Safety, settling and coping: Developing resiliency with dance/movement therapy

Because dance/movement therapy focuses on the integration of somatic sensations, it can facilitate access to traumatic memories, which are not initially accessible via verbal processing and are generally stored as images and physical sensations. Grounding, mirroring, resourcing, building strength, and use of metaphor, working with bodily held memories, touch and more, can

help clients manage the overwhelming stress tied to continuous race-based trauma. A dance/movement therapist working with such clients must attend to the establishment of safety, assist clients in settling their bodies and regulating their emotions – as opposing to repressing or invalidating said emotions – as well attend to interoception, one’s conscious awareness of bodily responses (Porges, 2017).

Although consistent external safety cannot be guaranteed given that Afrodescendants do not exist in a post-trauma environments, dance/movement therapists can still endeavor to create periodic safety and facilitate the internalization of safety within clients. Doing so is crucial as it has been established that stability and safety are foundational when working with trauma, specifically a felt sense of safety. Dance/movement therapists can work in concert with clients to create an internalized felt sense of safety, ensuring also that the client is not continually overwhelmed and providing assurance that difficult sensations can be managed. Safety is not, as Porges (2017) conceptualizes, the removal of all threat; rather, it is a subjective feeling that depends on environmental clues. Navigating specifically “neuroception”, the process by which an individual detects risk in their environment in and determines a response thereto, dance/movement therapists can intervene using above-mentioned tools: grounding, mirroring, resourcing, etc.

A slow progression for creating a sense of safety that begins with attention to the environment, then attention to body boundaries, and finally attention to sensation within the body, acts as “a gentle path that leads a client’s dissociative state toward the integrated experience of embodied awareness” (Tantia, 2013, p. 96, as cited by Dieterich-Hartwell, 2017). Therapists can also endeavor to foster a safe and secure environment through creating an inviting, comfortable, consistent and unchanging space, and by encouraging clients to bring one or more objects that

would generate comfort and security (Dieterich-Hartwell, 2017), objects that may eventually inspire improvised movement.

The therapist's facial expression, voice intonation and head gesture can convey the appropriate cues to facilitate a "settling" in the body of the mover. "Accessing settledness" can help Afrodescendants experiencing continuous race-based trauma to manage stress, build "sustained resistance" and create a sense of organization in the body through allowing the nervous system to find coherence and flow (Menakem, 2017, p. 153). A calm and settled body is the foundation for health and healing and learning to settle it is about managing the stress that comes rather than reducing it. It is important for the dance/movement therapist to enter interactions with movers with a settled body as well, as one settled body invites others to settle as well.

Breath has long been one favored way of settling, or *regulating*, the body. Breathing exercises can be used for self-regulation, but within a therapeutic setting, they can be used for co-regulation, bringing two bodies into a place of greater calm. For a dance/movement therapist and mover to engage in simultaneous breathing activities is an intervention that calls on a fundamental aspect of the practice: mirroring. In this example, the therapist would be practicing alongside the mover one of the most fundamental movements of life, expansion and contraction with the intake and expulsion of air. Mirroring has long been thought to enhance emotional understanding and empathy (McGarry, 2011), and here it has the added potential to prepare the body foundationally for further exploration. Sharing breathing patterns in a dance/movement therapy group can contribute to a stronger sense of connection.

Dance/movement therapy can also facilitate the access to and eventual embodiment of resilience, the capacity to bounce back after stress and trauma. Given the external environmental

context of continuous, repetitive traumatization, the search for resilience does not eliminate stress or pain; rather in the session, there is a recognition and acknowledgement of the grief, sadness and pain that follow these events, and resilience comes partially through working those emotions and the effects of the stress through the body (Serlin, 2020). Dance/movement therapy can build resilience at the body level, by incorporating the supportiveness that inherently comes with foundational principles such as mirroring, especially as it concerns the “five anchors” discussed by Menakem (2017): soothing and settling the body; noticing the sensations; accepting discomfort without fleeing but allowing the self to allow flow into other states of being as the session progresses; staying present in the body as the session unfolds, simultaneously building tolerance for ambiguity and uncertainty; and, finally safely discharging within the empathic and safe container of the therapeutic relationship, any stressful energy lingering in the body.

Dance/movement therapy *teaches* self-management skills and allows the mover to tap into their own embodied wisdom. A dance/movement therapy setting, whether within a group, or the dyad of therapist and mover, models – perhaps for the first time – what supportive, safe relationships can look like, embodied information that the mover can then live from and bring to relationships with family members, peers and others.

Dance/movement therapy also *teaches resourcing* (Ross, 2018). Using some of the above-mentioned tools, such as memories or objects that evoke calm, peace or joy to inspire movement interventions not only help to strengthen an individual’s capacity to cope with overwhelming nervous responses, but will facilitate the physical release of energy without heightening or bringing about additional emotional distress. In using these tools which the individual already possesses, the dance/movement therapist is inviting the individual’s mind and body to attune, or come into

the same frequency as safety. During such movement interventions, the mover is teaching their nervous system that in situations of stress, it is also possible to come back to a state of calm equilibrium. The dance/movement therapist is integral here in supporting the mover to consciously use those resources, and to facilitate presence and a sense of grounding.

Restoring empathy: The relationship between mover and dance/movement therapist

While the therapeutic relationship can be seen as a construct with varying degrees of effectiveness or destructiveness depending on theoretical framework, power differential between therapy practitioner and client/patient, as well as other factors, the relationship itself is arguably the most important factor, the container within which all things in therapy happen. In a therapeutic context, how the individuals engaged in the relationship relate is crucial and sets the stage for restoration to take place. Recognition and mutuality play a role in the effectiveness of the therapy itself (Jordan, 2018). As such, the relationship built between group members and dance/movement therapist or between dance/movement therapist and mover may be the most important part of the healing process. Much of continuous race-based trauma is enacted through interpersonal interactions or the witnessing of such interactions, which is known as secondary trauma. Having established in the literature review the deleterious effect of such interactions, and the toll that inhumane disregard and misrecognition have on individuals living in black bodies, then the practice of empathy, specifically through an embodied practice, opens the door to the restoration of feelings of self-worth, belonging, self-esteem, both individual and collective, a sense of agency, and a renewed recognition of where power *could* lie.

In working with any population, it is important to understand the client's culture of origin. In more homogenous therapeutic structures, where therapist and client or therapist and group

members share cultural identifiers, and where there is a felt sense of having a common background, this step may be omitted, but when working with Afrodescendants, who are so often misrecognized or whose interactions with others have been severely distorted by stereotypes and expectations based thereon, understanding cultural background is crucial in addition to the application of emotion-regulating somatic or movement techniques. It is helpful within the context of the therapeutic relationship to create an environment in which the sharing of the client's culture can happen and be met with acceptance. And this type of facilitation requires that the clinician also have an understanding of their own "habitus", or how their particular background influences how they perceive and react to the world.

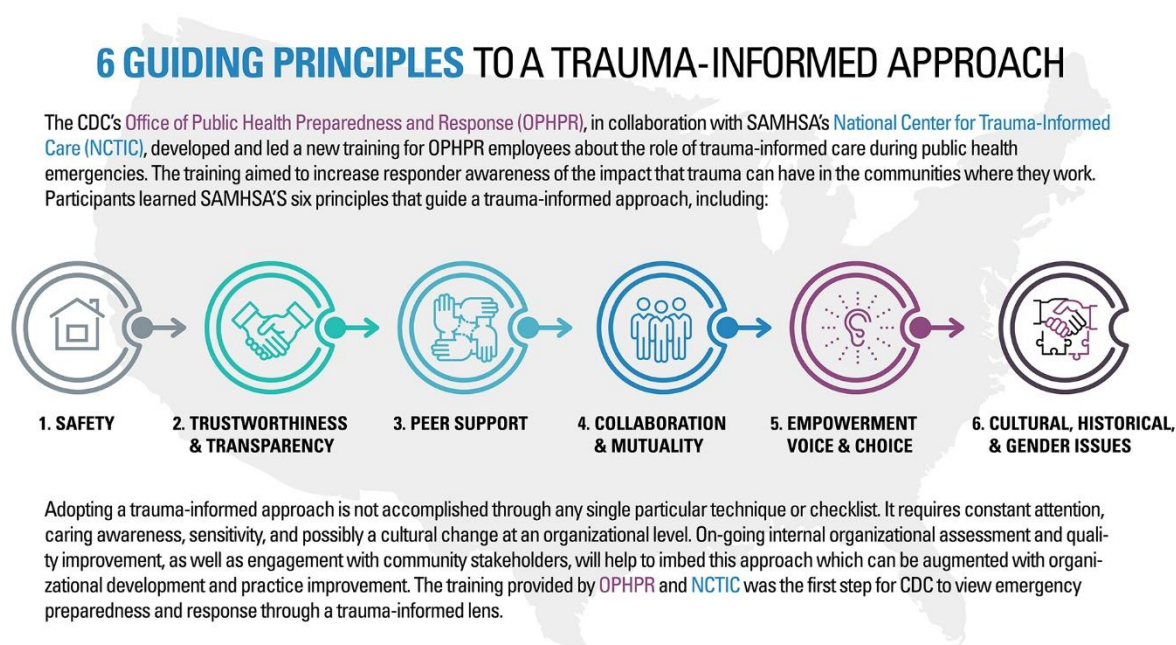
The social engagement system as theorized by Porges (2017) projects bodily feelings and is a portal for changing bodily feelings along a continuum that extends from a calm, safe state that would promote trust and love to a vulnerable state that would promote defensive reactions. Inherent in dance/movement therapy is the social engagement and safety mechanism. From a polyvagal perspective, clinical interactions that involve, looking, listening and witnessing illustrate relevant features of the theory. A dance/movement therapist takes into consideration bodily feedback that contributes to the subjective feelings manifested in our mood states and emotions. The process of looking and listening captures an important attribute of the social engagement system, since the process of looking at a person constitutes both an act of engagement and projects the bodily state of the observer. Based on the projected bodily state of the observer, the person being looked at will feel that the looker is welcoming or disinterested. Feeling and witnessing the client encompasses the therapists' bodily reaction to the client's engagement behavior and the projection of the bodily feelings embedded in the therapists' reciprocal engagement behavior.

Looking, listening and feeling the other in the therapeutic moment is an illustration of the dynamic bidirectional communication between bodily state and emotional processes during a social interaction; for the social interaction to be mutually supportive and to enable a coregulation of physiological state, the expressed cues from the dyad's social engagement systems need to communicate mutual safety and trust; when this occurs the active participants are now safe in each other's arms; the process of obtaining the state of a shared intersubjective experience is metaphorically like entering the code into a combination lock and suddenly the tumblers fall into place and the lock opens. These opportunities to connect and co-regulate determine the success of relationships. The social engagement system is not solely an expression of the individual's physiological state but may act as a portal of detection of distress or safety in others. When detecting safety, physiology calms; when detecting danger, physiology is activated for defense. We would in fact be using the establishment of healthy relationship to help treat trauma.

Embodying a trauma-informed approach

Dance/movement therapists, furthermore, can incorporate the following principles into their work. The Centers for Disease Control's Office of Public Health Preparedness and Response in conjunction with the Substance Abuse and Mental Health Services Administration have set out six principles that would guide a trauma-informed approach to care (CDC, 2020). Using safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical and gender issues to inhabit the space, dance/movement therapists can begin to build a framework that is supportive of the kind of work that would facilitate the healing of Afrodescendants struggling with continuous race-based trauma.

Figure 1. Six Guiding Principles to a Trauma-Informed Approach to Therapy



Note: Reproduced from the Centers for Disease Control and Prevention, Center for Preparedness and Response, 2020 (https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm). In the public domain.

Creating safety within the context of the trauma-informed relationship between client and dance/movement therapist calls for awareness and sensitivity. That can include asking for consent during movement interventions and inquiring into what feels tolerable for the client. That can include varying degrees of transparency, such as a verbal narration of the therapist's movements and intentions as the session progresses. That can also include refraining from rushing or forcing the client past what they are ready to reveal either in word or movement, but instead allowing their personal unveiling to take place at a pace with which they are comfortable. Alternatively, it can

include taking steps to help the client regulate or successfully regain equilibrium at times of distress or overwhelm.

Dance/movement therapists can “trigger” the cues of safety, in particular by being intentional about their movement. Clinicians might, for example, exercise awareness with respect to what the mover might consider an invasion of their personal space. Such sensitive use of space can be of particular importance to the population under consideration, as individuals living in black bodies have often been taught that they cannot occupy space comfortably or without some degree of fear or anxiety. With feelings of safety dependent on the “cues of safety” that calm the autonomic nervous system, and that calming then promoting opportunities to create safe and trusting relationships, in turn increasing opportunities for coregulation of behavioral and physiological states (Porges, 2017), we have a “circle of regulation” that defines healthy relationships in which the relationship supports both mental and physical health. Dance/movement therapy as a treatment model is supportive, responds to the biological imperative of connectedness, and provides the necessary framework to create such safety.

References

- American Public Health Association. (n.d.). *Racism and health*.
- BBC News Reality Check Team. (2020, June). *George Floyd: How are African-Americans treated under the law?* BBC. <https://www.bbc.com/news/world-us-canada-52877678>
- Bowen, E.A., & Murshid, N.S. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health, 106* (2), 223–229. <https://doi.org/10.2105/AJPH.2015.302970>
- Centers for Disease Control and Prevention. (2020, December 10). *COVID-19 Racial and ethnic health disparities*. CDC. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html>
- Cantrick, M., Anderson, T., Leighton, L.B., & Warning M. (2018). Embodying activism: Reconciling injustice through dance/movement therapy. *American Journal of Dance Therapy, 40*, 191–201. <https://doi.org/10.1007/s10465-018-9288-2>
- Dieterich-Hartwell, R., Goodill, S., & Koch, S. (2020). Dance/movement therapy with resettled refugees: A guideline and framework based on empirical data. *The Arts in Psychotherapy, 69*. <https://doi.org/10.1016/j.aip.2020.101664>
- Guidi, J. Lucente, M., Sonino, N., & Fava G. A. (2020). Allostatic load and its impact on health: A systematic review. *Psychotherapy and Psychosomatics, 90*, 11–27 <https://doi.org/10.1159/000510696>
- Harris-Perry, M. (2011). *Sister Citizen: Shame, Stereotypes, and Black Women in America*. Yale University Press.

- Jordan, J. (2018). *Relational-Cultural Therapy*. (2nd ed.). American Psychological Association.
<https://doi.org/10.1037/0000063-001>.
- Louis-Jean, J., Cenat K., Njoku, C. V., Angelo, J., & Sanon, D. (2020). Coronavirus (COVID-19) and racial disparities: A perspective analysis. *Journal of Racial and Ethnic Health Disparities*, 7(6), 1039–1045. <https://doi.org/10.1007/s40615-020-00879-4>
- Menakem, R. (2017). *My Grandmother's Hands: Racialized Trauma and the Pathway to Mending our Hearts and Bodies*. Central Recovery Press.
- McGarry, L.M. & Russo, F.A. (2011). Mirroring in dance/movement therapy: Potential mechanisms behind empathy enhancement. *The Arts in Psychotherapy*, 38(3), 178–184.
<https://doi.org/10.1016/j.aip.2011.04.005>
- Mencagli, M. & Nieri, M. (2019). *The Secret Therapy of Trees: Harness the Healing Energy of Forest Bathing and Natural Landscapes*. (J. Richards, Trans.; 2nd ed.). Penguin Random House. (Original work published 2017)
- Nickerson, A., Bryant, R. A., Rosebrock, L. & Litz, B. T. (2014). The mechanisms of psychosocial injury following human rights violations, mass trauma, and torture. *Clinical Psychology: Science and Practice*, 21(2), 172–191. <https://doi.org/10.1111/cpsp.12064>
- Pinderhughes, H., Davis, R. A., & Williams, M. (2015). *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma*. Prevention Institute.
<https://www.preventioninstitute.org/sites/default/files/publications/Adverse%20Community%20Experiences%20and%20Resilience.pdf>
- Pitner, B. H. (2020). *Viewpoint: US must confront its original sin to move forward*.
<https://www.bbc.com/news/world-us-canada-52912238>

- Porges, S. W. (2017). *The Pocket Guide to the Polyvagal Theory: The Transformative Power of Feeling Safe*. W.W. Norton and Company.
- Ross, S. (2018, March 3). *Resourcing, pendulation and titration: Practices from Somatic Experiencing®*. <https://sarahrossphd.medium.com/resourcing-pendulation-and-titration-practices-from-somatic-experiencing-a3dd4909376>
- Serlin, Ilene A. (2020). Dance/movement therapy: A whole person approach to working with trauma and building resilience. *American Journal of Dance Therapy*, 42, 176–193.
<https://doi.org/10.1007/s10465-020-09335-6>
- Shervington, D. (2018). *Healing is the Revolution*. Institute of Women and Ethnic Studies.
- Van Der Kolk, B. (2014). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Penguin Books.