

Dance/Movement therapy and resilience building with female asylum seekers and refugees: a phenomenological practice based research

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This phenomenological study aims to better understand the applicability of Dance/Movement therapy for traumatised women asylum seekers and refugees. It explores if and how bodily engagement could support an existing resilience based treatment model employed at a centre for transcultural psychiatry in the Netherlands. The sessions focused on moving the body and included the use of music, props, mirroring techniques, body awareness and movement exploration exercises. Participation in the sessions was associated with self-reported alleviation of stress and addressed vulnerabilities. Additionally, movement and bodily engagement offered opportunities for body awareness, and interconnectedness with other group members. A key finding was that Dance/Movement therapy provided a shared safe psychological space for self-expression among this vulnerable population, and can be incorporated into a resilience based treatment programme with adaptations for context.

Keywords: asylum seekers, Dance/Movement therapy, phenomenological study, post-traumatic stress, refugees, resilience, trauma

Introduction

This phenomenological study focuses on the applicability of Dance/Movement therapy (DMT) with female asylum seekers and refugees in the Netherlands. DMT is a nonverbal, creative therapy defined by the American Dance Therapy Association as

Key implications for practice

- Dance/Movement therapy focusses on the body to strengthen and complement psychosocial mental health programmes for refugees and asylum seekers
- Movement based interventions can help maintain and strengthen resources and contribute to resilience building
- Dance/Movement therapy can be adapted to various cultural contexts, settings and populations

the psychotherapeutic use of movement to further an individual's emotional, cognitive and physical functioning. DMT differs from other forms of psychosocial interventions and creative therapies (i.e. music, drama and art) in its direct and extensive use of the body, using movement as medium for self-expression, self-awareness and as a means of communication with others. DMT mobilises both the mind and body while fostering coping mechanisms and focussing attention on psychosocial issues (L'Abate, 2007).

It is important to study DMT as it could contribute a response to the growing mental health needs of asylum seekers and refugees globally. The modality's added value lies in

its cross-cultural adaptability to various populations within a broad spectrum of applications from individual to group therapy and clinical to community settings (Gray, 2011; Johnson, Lahad, & Gray, 2008; Koch & Weidinger von der Recke, 2009; L'Abate, 2007). In recent literature, authors underline the importance of understanding what factors could enhance asylum seekers' and refugees' resilience to promote their mental health (Harvey, 2007; Kohli & Mather, 2003; Thomas, Roberts, Luitel, Upadhaya, & Tol, 2011). Specifically for asylum seekers and refugees, maintaining and regaining resources (e.g. material, financial, psychosocial) to achieve wellbeing, despite traumatic past experiences and ongoing daily life stressors, has been stressed as being part of resilience building (Laban, 2010). Research also suggests that long asylum procedures contribute to a higher prevalence of psychopathologies due to post migration adversities and lack of social support, and advocate a resilience oriented treatment (Agaibi & Wilson, 2005; Chan, Chan, & Ng, 2006; Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Whittaker, Hardy, Lewis, & Buchan, 2005).

A modest body of literature on creative arts therapies applied with asylum seekers and refugees suggests beneficial effects in the reduction of symptoms whilst contributing to resilience building due to their nonverbal, resource oriented approaches and transcultural applicability (Bensimon, Amir, & Wolf, 2008; Dokter, 2000; Gray, 2001, 2008, 2011; Harris, 2007a, 2007b, 2010; Koch & Weidinger von der Recke, 2009; Rousseau et al., 2007; Orth, 2004). To date, there has been a lack of exploration of the acceptability and interpretation of DMT among asylum seekers and refugee populations.

DMT practitioners have adapted their approach when working with traumatised populations (Gray, 2008, 2011; Harris, 2007a, 2007b, 2010; Koch, Fuchs, Summa & Muller, 2012; Pierce, 2014). In the literature on DMT and trauma, most models of intervention

apply similar approaches, which can be divided into four key concepts using the body as a focus for change (Verreault, 2014): (1) *kinesthetic empathy* refers to attuning to others by witnessing and observing movement, dance and gesture, for example in the use of movement circles and mirroring techniques; (2) *desomatization of symptoms* refers to the understanding of bodily experiences, for example the use of body awareness and grounding techniques; (3) *symbolisation and creativity* refers to the creative process in movement, for example the use of movement metaphors, imagery, personal narratives and symbolic play; and (4) *ritual and ceremony* refers to the use of simple movement structures, for example to mark life transitions (e.g. farewell) or the beginning and ending of DMT sessions (Eberhard-Kaechel, 2012; Gray, 2001, 2008, 2011; Harris, 2007a, 2007b, 2010; Johnson, 2009; Koch & Weidinger von der Recke, 2009; Koch, Fuchs, Summa & Muller, 2012; Kornblum & Halsten, 2006; Koss-Chioimo, 2006; Lee, Lin, Chiang, & Wu., 2013; MacDonald, 2006; Meekums, 2012; Monteiro & Wall, 2011; Moore, 2006; Pierce, 2014; Stepakoff, 2007; Williams, 2006). Capacity building for clients is essential to avoid possible retraumatisation triggered by working so closely with the body (Koch, Kolter & Kunz, 2012b). At times, a more distant approach to the body might be required (Gray, 2001, 2011; Levine, 2010; Moore, 2006; Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, McFarlane, & Weisaeth, 2012).

Despite the scarcity of rigorous evaluations of DMT, two recent studies, one demonstrating an association between DMT interventions and improvement in quality of life (Brauninger, 2014) and the other, a meta-analysis study on the effectiveness of DMT (Koch, Kunz, Lykou, & Cruz, 2014), investigated which DMT interventions could be beneficial to alleviate stress, increase coping or reduce depression and somatic complaints. Further, research informed interventions on posttraumatic stress disorder (PTSD), combining DMT and somatic

experiencing underline the importance of embodying personal coping and resources through sensations and movement (Spanglet, Meirav, & Shacham, 2013). Lastly, Lahad, Shacham, & Ayalon's (2013) Resilience Model; BASIC Phⁱ was studied extensively and widely used with traumatised populations by mental health practitioners in cross-cultural settings (Farchi, 2013).

This qualitative research aimed to provide a better understanding of the applicability of DMT for a group of traumatised female asylum seekers and refugees. It explored generated themes (e.g. verbal, nonverbal, sensorial, emotional, cognitive) through bodily engagement during four DMT sessions and how they might support an existing resilience oriented treatment programme employed at a centre for transcultural psychiatry in the Netherlands.

Methods

This study took place in a centre providing mental health care services to clients from different cultural backgrounds, predominantly asylum seekers and refugees. The

prevalent treated disorders are: (a) PTSD; (b) depression; (c) anxiety, and (d) somatoform, often complicated by post migration adversities (Laban, 2010). Assessment and treatment follow a resilience focused approach, combining concepts of vulnerability and stress in relation to personal strengths and social support. Figure 1 illustrates the quadrant resilience model applied at the centre. Five resources are used to operationalise the concept of resilience: (1) psychological, (2) physiological, (3) social, (4) religious/spiritual, and (5) cultural resources. Furthermore, a culturally sensitive psychosoma education package is included in the treatment programme.

DMT intervention

This study focused on four weekly DMT sessions of 75 minutes each, for a period of one month. Sessions were facilitated by a DMT practitioner with a Drama therapist as co-facilitator. For the purpose of this study, each of the DMT sessions followed a five part structure consisting of: (1) *check-in and opening ritual* (verbal/nonverbal), to mark

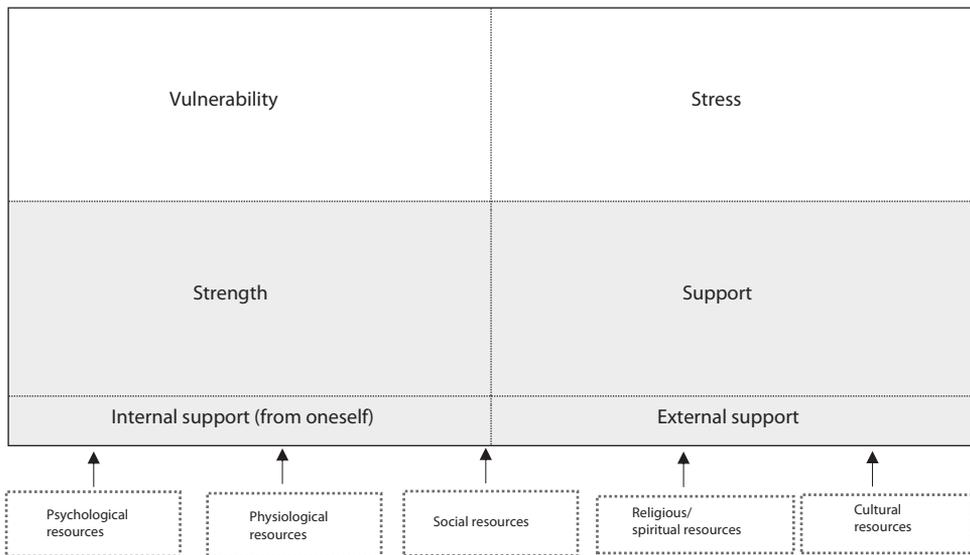


Figure 1: Resilience model applied at the centre.

the beginning of the session in movement and offer opportunities for sharing, grounding, connecting to others and reviewing the past session; (2) *body warm-up*, to prepare and activate the body for further movement experiences during the session; (3) *theme development*, emphasising movement based explorations related to movement themes emerged from the warm-up or check-in round; (4) *verbal and nonverbal processing* of experiences is intertwined throughout the session; and (5) *closure and end ritual* (verbal/nonverbal), to provide a cooling down and symbolically close the session. The five part structure offers a framework, but the inputs of the women and their moving bodies directs the content of the session. Sessions were conducted in the drama therapy room allocated for the therapy programme at the centre. The DMT sessions focused on bodily engagement and included the use of music, props, mirroring techniques, body awareness and creative movement exploration exercises. After each session, participants were invited to participate in a brief focus group discussion (FGD), based on movement experiences during the sessions, which was part of the research design as explained below.

Sample

The participants for this study were an existing group of eight female asylum seekers and refugees undergoing a two-day, weekly, resilience based therapy programme at a centre for transcultural psychiatry in the Netherlands. The group was mixed in terms of country of origin, trauma history, age, marital status, language, cultural and religious background. The duration of displacement ranged from 1 to 13 years. The participants' countries of origin were: Afghanistan, Armenia, Democratic Republic of Congo, Kosovo, Sierra Leone, Somalia, Togo, ranging from 19 to 50 years old. Of the women, two had obtained refugee status, the other six were seeking asylum. DMT

was newly introduced to the programme four months prior to the study. All of the women suffered from a combination of severe traumatic complaints, mostly accompanied by depressive and somatic symptoms.

Procedure

The study used qualitative methods, adopting an exploratory phenomenological design, a small scale study that focuses on the identification of a common shared lived experience and common meaning among participants (Adams, 2001; Gray, 2013; Groenewald, 2004). Three qualitative methods were used for data collection allowing triangulation. Data were collected through post session observation notes which included: (a) words that summarised the sessions; (b) movement phrases that reflected the session; and (c) session observation notes. Secondly, a 20 minute FGD was conducted at the end of every session, focusing on movement experiences among the participants. Third, two individual in-depth exit interviews with participants were conducted. A participant observer was appointed for note keeping during the interviews. The nonverbal and verbal content of the FGD was captured in writing by the co-therapist. Finally, a 'memory roll' (a large, wide roll of paper on which visual summaries of the sessions in forms of collage, drawings and paintings were made) was used throughout the process to address possible recall bias and to document session content.

Ethical considerations

This study was approved by the ethical committee Dance Therapy at CODARTS, University of the Arts, Rotterdam, the Netherlands. The research methods were adapted to avoid participant burden as much as possible. Participants were informed that interview content would not relate to traumatic past experiences. Consent for the study was sought from the participants

at the beginning of the first session. Participants were briefed prior to the study, accompanied by a witness for this purpose. Ongoing psychological and psychiatric services were available to all participants throughout the therapy programme.

Analyses

All data collected was compiled, transcribed and categorised into one single document. Analysis followed steps from phenomenological approaches (Adams, 2001) and qualitative thematic framework analysis (Hsieh & Shannon, 2005). The analysis consisted of six steps: (1) transcribing data according to the different data sets; (2) familiarisation with data; (3) generating initial codes; (4) identifying themes within the coded data; (5) clustering and grouping of themes; and (6) interpretation of categorised data. A second coder (a researcher in the field of mental health) was used for steps three and four. The last step of the analysis consisted of understanding the level of compatibility between the theoretical resilience framework used at the centre (as described above) and the themes generated throughout the DMT sessions.

Results

Findings

The findings are presented following the five resource components that are part of the theoretical framework used at the centre: (1) social; (2) physiological; (3) psychological; (4) religious/spiritual; and (5) cultural resources. Of note, double coding was allowed so that some themes could be coded under multiple resource components. Figure 2 presents an overview of the findings and their relation to the resilience framework, its resource component, the modality and the context in which the research took place. Direct quotes and excerpts from the raw data are in quotation marks while findings are italicised throughout the text.

Safety

Safety, a recurring theme in this study, is considered both a psychological and physiological resource. For this reason, it is identified as an overarching theme and consists of four sub-themes: *safe space*, *taking time*, *respect of physical and emotional boundaries* and *being at ease*.

Safe space and taking time

The therapeutic setting seemed to provide a safe haven and learning environment for all participants on a physical and emotional level: The words '*doing calmly*' were used to describe how most participants experienced the exercises in the sessions. *Taking time* to do things was experienced positively: '*I like it that we take time*'. The women also experienced time for themselves and the importance of simply being: '*everyone can do what they want or what is good for their bodies*'. The use of the floor (the carpeted area) was used without shoes for movement experiences, whereas rest moments, relaxation and group discussions were interchanged throughout the sessions. One participant related the following comment about the space: '*I feel good in this room*'.

Respect of physical and emotional boundaries

The possibility to do their '*own*' movement and with the respect of limits is underlined by many participants: '*if we cannot do or don't want to do it in this way, it's ok*'. The women shared that the ability '*to be*' and do what they needed for their bodies was good. Other participants showed lack of boundaries and limits towards others and themselves while moving. For example, one member wanted to push herself to continue the exercise because of the coziness and pleasurable moment with the others, although she was feeling stuffy: '*I had to stop. I needed air*'. At times, participants needed to be reminded of their limits and to move in careful ways for their bodies and take rest if required. A participant shared that she needed to punch her legs when invited to do a self-soothing gesture so that she

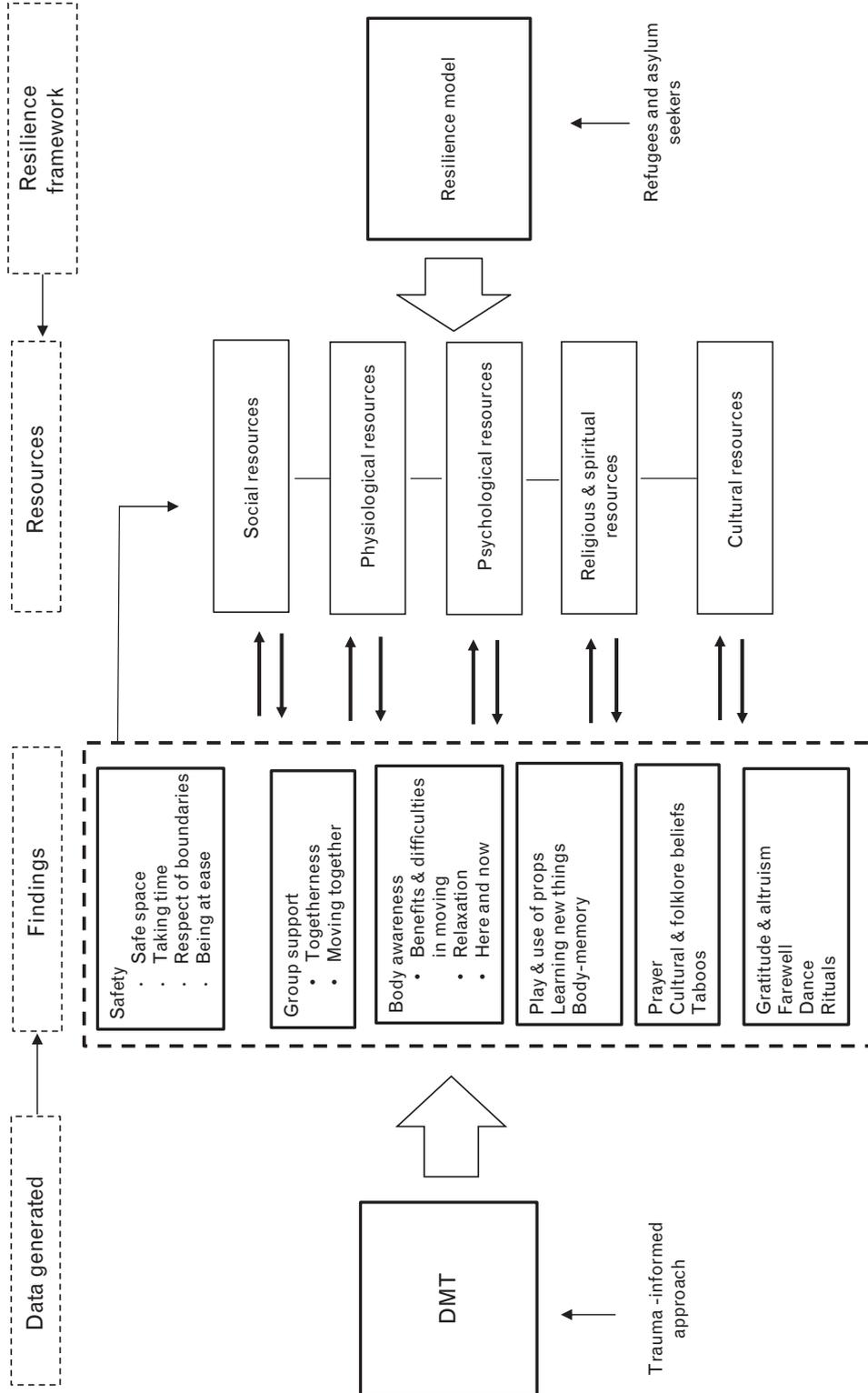


Figure 2: Conceptual framework of the findings.

could feel something (i.e. she experienced numbness).

Being at ease

Taking care of oneself, noticing inner sensations, creating a safe area (the carpeted floor area), breaking with the common chair set-up for verbal therapies, all of these supported the creation of a private space where participants felt at ease. *Offering the choice* to take the lead or not, to use music or not, to turn off the music, to rest or lie down, to inquire about their bodily needs during the sessions appeared to alleviate stress and to foster a sense of *being at ease*.

Social resources

Group support: togetherness and moving together

Participants mentioned the importance of being part of the group: of *'being together'*, *'moving together'*, *'playing'*, *'cooperation'* and *'sharing'*. Many participants shared that being in the group made them realise they were not alone and that other people shared the same problems. Women spoke about their appreciation for the laughter during the movement games. The theme of *togetherness* and the value of a private space in which to meet seemed to be significant for them.

Physiological resources

Body awareness

On numerous occasions, participants shared, noticed or inquired about the sensations experienced in their bodies: flushed skin, warm flushes, dizziness, sounds of cracking bones, heaviness in the body, numb sensations in the legs, pain felt in the neck and rapid heartbeats. The women began to attend to these bodily sensations and the sounds of their bodies (yawns, sighs, breathing), their impulses to move or not and the difficulties experienced in moving. Participants also experienced or acknowledged their bodily limits while moving. Moreover, through bodily engagement, the women explored beneficial movements for their bodies and observed changes in their postures before

and after the sessions: *'when I come here, I am like this!* (participant shows closed shrinking posture and cups her hands together), *but after a while, I'm like this!* (participants opened her arms wide and lengthened her spine).'

Benefits of moving

Some women talked about the *'rest from inside'* as a result of dancing and moving. One participant appreciated the *'joy of the group'*. Others experienced laughter during some of the movement activities. One participant noticed that by moving, she didn't *'go away'* (e.g. dissociation). One participant reflected that her movements made her thoughts disappear. She explained that by doing things it kept her stress or thoughts away so that she remained in the *here and now*.

Difficulty in getting into movement

All participants expressed and showed difficulties in getting into movement, most importantly expressed as tiredness in *'their minds and bodies'*. The beginning of the sessions were the most challenging. The heaviness was also observed in the women's body postures and gestures (e.g. shrinking postures, heavy limbs, resting heads on arms, heads dropping down or the constant need to sit between exercises). Difficulty in moving, lack of focus and concentration was often attributed to: bad nights, headaches, physical complaints, daily life events, and long travel time to get to the therapy.

Relaxation

Acknowledging the participants' tiredness and offering moments of relaxation, silence and rest time between activities seemed to enhance their sense of safety, the here and now and their ability to let go. Working on the floor was particularly useful to address the participants' tiredness. Women lay on the floor, collapsed and stretched out freely on the carpet. However, three participants shared that resting was difficult at times because of continuous thoughts and memories.

Here and now

Movement was used to allow participants to be present in their bodies, to build the awareness needed to stay in the *'here and now'* and be *'together'*. Attention needed to be given to hyper and hypo arousal and somatic complaints. The participants talked about how moving alleviated some of their thoughts and stress. A participant shares: *'One forgets . . . not forgets, but feels more here in the present instead of being in lots of thoughts.'*

Psychological resources*Play and the use of props*

The use of props (e.g. balloons, feathers, string, postcards) facilitated engagement and generated curiosity, surprise, playfulness and focus towards each other. The introduction of small movement explorations, such as working from the hands or feet during warm-ups, assured titration. Others mentioned that they felt cooperation when working with the props through touch, focus and *activation*. Meaning, such as connection, excitement and *play* was attributed. More so, humour, concentration, silence, pleasure and teasing emerged while engaging in these exercises. In the interventions, an attempt was made to bridge focus deficits through building awareness and attention to the task through body action. For other participants, creative movement experiences facilitated expression of affect. One participant used the meaning of her name as a metaphor to express how she felt and experienced her present life situation: *'I feel my wings have been cut off. I'm not free. Sometimes I feel free here.'* Her insight was generated by a movement exploration activity when writing her name in space.

Body memory

Building new positive bodily experiences combined with successful experiences in movement (i.e., leading a movement, teaching an African dance) seemed to provide a sense of empowerment, self-agency and connectedness. During FGD, the participants'

bodies often responded before verbalising their experiences. For example, bodily actions like wiggling toes, moving fingers or slamming and bouncing balloons, shoulder rolls and punching actions indicated some recollection of movement experiences during the sessions. A participant explained after leading a dance from her country: *'I enjoyed it because it's from my country; it's from me, part of me.'* Another participant expressed: *'I've been here too long, I forgot the dance of my country.'*

Through spontaneous explorations, symbolic play and creative processes in movement, participants explore and unfold their resources in the *here and now* and experience sensations of pleasure and pain in their bodies while making contact with some of their cultural resources stored in the form of body memories. For the majority of women in the group, *dance* played an important part of their cultural identity. For two women, movement provided *'power and peace inside'*. Participants from different countries also showed interest in other participants' style of moving.

Learning new things

The interventions allowed successful experiences in movement, enhancing a sense of mastery and self-agency, while for others it offered learning opportunities and new *'stimuli'*. Participants expressed the importance of learning new skills: to lead or the wish to learn to do so. A few participants could experience others' ways of being in movement, expressing their need for love and warmth by showing self-soothing gestures or experiencing a sense of freedom from the past in spontaneous movement action.

Religious/spiritual and cultural resources*Prayer and folklore beliefs, cultural taboos, dance*

New rituals, cultural taboos and folklore beliefs were discovered and shared throughout movement activities with the

participants. For example, a ritual posture was added to the opening ritual. The posture was familiar to the Muslim prayer position and developed from the women's need to stretch and rest in this posture. The posture was combined with murmurs of prayer, recitation for some and long exhalations for others. Participants could re-enact or reconnect to gestures and movements of prayers and dance from their home countries. Movement explorations like writing their names in movement or carrying pots on their head related to their cultural identities. Curiosity, pain, excitement, pleasure, fear and a sense of pride was experienced in moving or talking about beliefs, traditions and languages (e.g. language script, the meaning of being left-handed). Another example is the end ritual called *I take/I leave*, initiated by a movement from a participant which showed her need to bury and stomp bad things she left behind.

Farewell, gratitude and altruism

Unexpected or unannounced departures of participants characterised the sessions. The *farewell* theme required containment and attention. The women talked about wanting to do things for the other, caring for each other and for themselves. *Gratitude, support* and *altruism* were expressed in movement through offerings in gestures, massages, prayers and dances.

Table 1 gives an overview of the study framework in relation to the resilience framework and indicates more specifically which DMT interventions contributed to the different goals of the five resources components.

Discussion

This study provides insights into how a structured DMT intervention could support a resilience-focused treatment approach with traumatised asylum seekers and refugees. The holistic nature of DMT and its focus on the body appears to strengthen existing resources within individuals in a group

setting while also addressing vulnerabilities. The findings underline the importance attributed to safety, group support, the benefit and challenges attributed to moving and address the need for both relaxation and activation. Attending to the mental health needs of asylum seekers and refugees is complex and multi-faceted. Traumatic experiences from the past, combined with insecure futures and destabilising lives at the reception centres, require the need for adaptable, yet consistent interventions fostering safety and wellbeing. My role as practitioner within this cross-cultural group needed to acknowledge differences, assure titration and break down movement exercises to remain within the participants' window of tolerance.

Concepts of DMT are used to build and provide a safe space. Participants could feel at ease for self-disclosure through nonverbal expression in a contained setting. The focus on bodily engagement supports participants in gaining awareness of their bodies and in connecting to others through movement, while respecting their own physical and emotional boundaries. Warm-ups, grounding and body awareness exercises alleviate stress and bridge the difficulty in getting into movement. The simple use of movement, gestures and rituals allows the group to work in a focused and paced way as recognised by trauma informed approaches (Foa, Keane, Friedman, & Cohen, 2008). A balance between movement activities and rest moments, addressing various idioms of distress, cultural differences, pacing and breaking down movement interventions in smaller working units were ways to foster and stimulate both physiological and psychological resources to meet more immediate needs. During the DMT sessions, safety could also be translated on a bodily level. Findings show that participants during sessions could experience a felt sense of safety (Levine, 2008). Issues such as containment and safety are also underlined in the literature relating to the psychosocial

Table 1: Resilience framework in relation to DMT interventions and findings

Resilience frame work		Study framework	
Resilience building	Goals	DMT interventions	Findings (themes)
Physiological resources	<ul style="list-style-type: none"> • Understanding the body • Physical exercise • Stress management 	<ul style="list-style-type: none"> • Body awareness exercises • Relaxation techniques • Grounding techniques • Dance techniques and creative movement improvisations 	<ul style="list-style-type: none"> • Body awareness • Benefits of moving • Difficulties in moving • Here and now • Being at ease • Safe space
Psychological resources	<ul style="list-style-type: none"> • Empowering self-esteem • Cognitive flexibility • Positive emotion 	<ul style="list-style-type: none"> • Movement improvisations • Exploring creativity with movement, gestures and props • Leading/following exercises 	<ul style="list-style-type: none"> • Play and use of props • Learning new skills • Body memory • Safety: respect of physical and emotional boundaries
Social resources	<ul style="list-style-type: none"> • Social relatedness • Meaningful activities • Creating social support 	<ul style="list-style-type: none"> • Movement circles • Sharing positive and negative affects with gestures, movement and metaphors • Movement based games 	<ul style="list-style-type: none"> • Togetherness • Moving together
Religious/spiritual resources	<ul style="list-style-type: none"> • Prayer • Faith • Installing hope • Meditation 	<ul style="list-style-type: none"> • Prayer and meditation rounds • Celebration and farewell rituals • Opening and closure rituals 	<ul style="list-style-type: none"> • Prayer and folklore beliefs
Cultural resources	<ul style="list-style-type: none"> • Cultural identity • Language skills • Acculturation • Sharing cultures 	<ul style="list-style-type: none"> • Exploring and sharing traditions, taboos, language through creative movement improvisations 	<ul style="list-style-type: none"> • Gratitude and altruism • Cultural taboos • Farewell • Dance

Note: The umbrella theme safety is divided between both physiological and psychological resources.

care for displaced populations in emergency settings (Hettenbach & Messina, 2010; Hobfoll et al., 2007; Hunter, 2013).

Another important phenomenon during this study relates to the experience of *'togetherness'*, more specifically expressed by the women as doing things together and moving together. Kinesthetic empathy, a key concept to DMT, relates to one's ability to feel another through movement (Behrends, Muller & Dziobek, 2012). One can feel the physical state of another while taking on the sensations, body postures and the sensory information related to another's movement (Behrends et al., 2012; Koch et al., 2012a; Meekums, 2012). This corresponds to research stating that empathy is rooted in our embodied experiences (Gallese, 2007). Restoring empathy, altruism and social connectedness are core elements in rebuilding individual, community and group social resources when working within the context of trauma (Drozdek & Wilson, 2004; Drozdek, 2014; Harris, 2007a; Mollica, 2006; Williams, 2006).

In this study, DMT contributes to stress reduction and capacity building by exploring and developing participants' physiological resources. Restoring bodily awareness is crucial in understanding the somatisation process of symptoms. The focus on the moving body through structured exercises and movement explorations appears to stimulate awareness to bodily sensations. For example, at the beginning of the sessions, grounding exercises, opening rituals or simple body warm-ups are used to stabilise and decrease physiological arousal and modulate anxiety symptoms triggered by difficult incidents at refugee centres. The participants' lived experiences during DMT sessions with regard to themes, such as *'respect of emotional and physical boundaries'* and *'being at ease'* coincided with building awareness in trauma work (Eberhard-Kaechele, 2012; Levine, Land & Lizano, 2015). Being at ease and feeling safe in the body contradicts the stress state that is typically experienced in the body

when suffering from PTSD. Working so closely with the body, however, can stimulate intrusive sensations and memories (Koch et al., 2012a). The experiences shared by the women related their difficulty in getting into movement attributed to physical pain, mental preoccupations, rumination and tiredness. The challenges faced by moving could also be due to avoidance and resistance to body work. This phenomenon was addressed and explored through titration (i.e. breaking tasks in smaller working units to allow participants to stay connected with their bodies) and the use of creativity (e.g. the usage of props, music and movement metaphors).

The role of creativity and symbolism is intertwined with the ability to play and improvise through creative movement explorations. Participants in this study expressed the positive experiences associated with moving and playing. The capacity to experience the bodily feeling of pleasure is consistent with recent literature when working with traumatised populations (van der Kolk, 2014; Levine, 2010). Authors describe the roles attributed to humour, play, laughter, and positive bodily experiences in promoting resilience (Bonnano, 2004). Similarly, Ogden and colleagues (2006) emphasise the importance of promoting play in individuals to restore creative, cognitive and imaginative resources. Moreover, in this study, through imaginative and symbolic play, with the use of props, rhythm, music and narratives in movement, the creative process is underlined and themes relating to shame, prayer, body image, group support, sadness, joy, motherhood, sexuality and cultural taboos emerged.

Lastly, the use of movement based rituals during the DMT sessions appears to enhance the participant's religious, spiritual and cultural resources and support self-healing practices. The beneficial effects of symbolism and ritual practices involving the body are valued healing mechanisms in many cultures worldwide (Hinton & Kirmayer,

2013). For example, during this study, one of the ways to address departure from members in the group, was through a ritual celebration combined with dance, prayers and offerings in gestures. DMT utilises sources from rituals and traditional healing practices of cultures around the world. This is one important reason why it could be an appropriate intervention for populations from different cultural settings.

Some limitations should be mentioned. Most importantly, it is not clear whether the findings relate uniquely to the four sessions and the practitioner's approach, to the women's experiences since DMT was introduced (four months prior to the study) or to other parts of their treatment programme at the centre. Participants, however, do underline important differences in their experiences between DMT and other therapies at the centre. Given the small sample size, the short duration and the qualitative nature of the research, it may be difficult to generalise the findings. Further studies are needed in other contexts and settings to evaluate the effectiveness of DMT with this population. Language barriers might have hindered the participants' ability to verbalise movement experiences for the purpose of the study.

Conclusion

To summarise, this study provides tacit knowledge on the cross-cultural applicability of DMT within an existing resilience based treatment programme employed for the mental health care of asylum seekers and refugees at a centre for transcultural psychiatry in the Netherlands. The findings show that emphasising the participants' cultural backgrounds, creativity and resources through bodily engagement during DMT sessions could alleviate stress, address vulnerabilities, increase self-agency, help regain a sense of bodily control and thereby enhance resilience. The session structure and the use of movement allowed themes relevant to physiological, spiritual, social,

psychological and emotional resources to emerge. The use of the body has been commonly advocated in the literature for treatment with people with traumatic complaints (Levine et al., 2015). Likewise, DMT interventions prioritise the body as a resource whilst supporting individuals reconnecting with themselves and others. In essence, participants in this study could explore their self-healing efforts, their strengths and difficulties on a bodily level and their ability to regulate both positive and negative effects through a wide range of movement experiences. This study shows that DMT can complement a resilience oriented framework, provide group support, create a safe space and promote resource building for asylum seekers and refugees.

In conclusion, the nonverbal nature of the modality and its movement based focus could be compatible cross-culturally, particularly for populations where distress is often manifested somatically (Hinton, Kredlow, Pich, Bui, & Hofmann, 2013). In a more distant future, in low and middle income countries it may be interesting to develop more integrated models where local community mobilisers and health workers can incorporate body work and creative movement in resilience oriented programmes for the mental health care for displaced populations. DMT can be appropriate across age and gender groups, provided it is adapted to the context, and this across all levels of care. Movement based interventions could complement existing psychosocial programmes in humanitarian and low resources settings, both to strengthen community and family supports and as focused non specialised interventions following recommendations for psychosocial support and mental health care in complex situations (Inter-Agency Standing Committee, 2007).

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